

**KEEPING THE PROMISE: ALLOWING SENIORS TO
KEEP THEIR MEDICARE ADVANTAGE PLANS
IF THEY LIKE THEM**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

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KEEPING THE PROMISE: ALLOWING SENIORS TO KEEP THEIR MEDICARE ADVANTAGE PLANS IF THEY LIKE THEM

THURSDAY, MARCH 13, 2014

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Whitfield, Shimkus, Murphy, Blackburn, Gingrey, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Pallone, Engel, Green, Barrow, Christensen, and Waxman (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Noelle Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Sydne Harwick, Legislative Clerk; Robert Horne, Professional Staff Member, Health; Chris Sarley, Policy Coordinator, Environment & Economy; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Tom Wilbur, Digital Media Advisor; Jessica Wilkerson, Legislative Clerk; Ziky Ababiya, Staff Assistant; Phil Barnett, Staff Director; Eddie Garcia, Professional Staff Member; Kaycee Glavich, GAO Detailee; Amy Hall, Senior Professional Staff Member; Karen Lightfoot, Communications Director and Senior Policy Advisor; and Karen Nelson, Deputy Committee Staff Director for Health.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The chair will recognize himself for an opening statement.

Nearly 15 million seniors, or almost 30% of Medicare beneficiaries, have chosen to enroll in a Medicare Advantage plan, an alternative to fee-for-service or traditional Medicare. Medicare Advantage or MA plans offer benefits not provided under traditional Medicare, such as reduced cost-sharing, vision and dental coverage, preventive care, and care coordination services. Numerous studies show that MA enrollees enjoy better health outcomes and receive higher quality care than those in traditional Medicare.

So who are MA beneficiaries? Medicare Advantage covers a disproportionate share of low-income and minority seniors when compared to traditional fee-for-service Medicare. Four in ten seniors with MA plans have incomes of \$20,000 or less. Medicare Advantage is fundamentally about offering seniors the choice of better healthcare through traditional Medicare. Beneficiaries choose the plans that best meet their individual health needs. And, according to the latest CMS National Health Expenditures data, more than half of new Medicare enrollees are choosing Medicare Advantage plans.

We should be encouraging seniors to take control of their healthcare and expanding this proven program. Instead, this Administration's policies are harming seniors by reducing their choices of high quality care through a series of cuts to the Medicare program that began with the Affordable Care Act.

According to the Congressional Budget Office, ObamaCare cut more than \$700 billion from Medicare and spent the money on new government programs not for seniors. CBO also has said more than \$300 billion of those cuts come from Medicare Advantage. Last year, CMS imposed regulatory cuts of 4 to 6% on MA plans, resulting in benefit reductions of \$30 to \$70 per senior per month.

And on February 21, 2014, CMS released its 2015 Advance Notice outlining changes to Medicare Advantage payment policies, which an Oliver Wyman study estimates will result in an additional cut of nearly 6%. This newest cut is projected to cause seniors to lose an additional \$35 to \$75 per month in benefits. According to experts, these cumulative cuts from the Democrats' policies on seniors could result in "plan exits, reductions in service areas, reduced benefits, provider network changes, and MA plan disenrollment."

The week before last, this subcommittee held a hearing on the Administration's assault on Medicare Part D prescription drug plans. Now, we are learning about more crippling cuts to Medicare Advantage. Why is the Administration dead set on pushing policies that harm seniors and using their Medicare program as a piggy bank to fund other healthcare programs?

Today, we will hear from a number of Members who have authored legislation that would improve the Medicare Advantage program for seniors. We also have witnesses who can speak to the harm that this Administration's policies have done to them.

I would like to thank all of our witnesses for appearing today. I will yield at this point the remainder of my time to vice chair of the subcommittee, Dr. Burgess.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.

The Chair will recognize himself for an opening statement. Nearly 15 million seniors, or almost 30% of Medicare beneficiaries, have chosen to enroll in a Medicare Advantage (MA) plan, an alternative to fee-for-service (FFS) or traditional Medicare.

MA plans offer benefits not provided under traditional Medicare, such as reduced cost-sharing, vision and dental coverage, preventive care, and care coordination services.

Numerous studies show that MA enrollees enjoy better health outcomes and receive higher quality care than those in traditional Medicare.

So, who are MA beneficiaries? Medicare Advantage covers a disproportionate share of low-income and minority seniors when compared to traditional fee-for-service Medicare. Four in ten seniors with MA plans have incomes of \$20,000 or less.

Medicare Advantage is fundamentally about offering seniors the choice of better health care than traditional Medicare. Beneficiaries choose the plans that best meet their individual health needs. And, according to the latest CMS National Health Expenditures data, more than half of new Medicare enrollees are choosing Medicare Advantage plans.

We should be encouraging seniors to take control of their health care and expanding this proven program. Instead, the Obama Administration policies are harming seniors by reducing their choices of high quality care through a series of cuts to the Medicare program that began with Obamacare.

According to the Congressional Budget Office, Obamacare cut more than \$700 billion from Medicare and spent the money on new government programs not for seniors. CBO also has said more than \$300 billion of those cuts come from Medicare Advantage.

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Why is the Administration dead set on pushing policies that harm seniors and using their Medicare program as a piggy bank to fund other health care programs?

Today, we will hear from a number of members who have authored legislation that would improve the Medicare Advantage program for seniors. We also have witnesses who can speak to the harm that this Administration's policies have done to them. I would like to thank all of our witnesses for appearing today.

Thank you, and I yield the remainder of my time to Rep.

Mr. BURGESS. I want to thank the chairman for yielding.

We do spend a lot of time in Congress talking about the problems in healthcare. The problem is we are so busy triaging the mistakes that we don't think about the things that are actually working. And Medicare Advantage is one of those things that is actually working.

What do we always talk about? We talk about disease management, coordinated care. We have talked about that in this committee in a bipartisan fashion for a long time, but guess what? Medicare Advantage plans are delivering on that promise. The President, however, decided to take money away from a working program in order to fund one that is dysfunctional. The President sold the Affordable Care Act on a foundation of false promises. You can keep your plan: false. You can keep your doctor: also not true.

President Obama told seniors he would use the money from Medicare to fund the Affordable Care Act, and at the same time improve Medicare for beneficiaries. In reality, these payment cuts are not going back to Medicare but instead they are funding other provisions of the Affordable Care Act. Along with less money to Medicare Advantage plans, the Affordable Care Act burdened plans with additional requirements.

The most recent proposed cuts to Medicare Advantage are part of a historic strategy of provider cuts that have always backfired. The sustainable growth rate is the leading example. It limits access

for seniors and doesn't reduce cost. It is time for the Administration to shift gears and change strategies. Don't fix what is not broken. It is time for the Administration to start addressing the real problem, the Affordable Care Act, and not look for problems that are nonexistent.

I yield back to the chairman.

Mr. PITTS. The chair thanks the gentleman and now yields 5 minutes for an opening statement to the ranking member, Mr. Pallone.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts. Unfortunately, I have to begin today's hearing expressing my disappointment in the tactics and process from your side of the aisle. This hearing has morphed from the future of Medicare Advantage, or MA, into what your side is now calling a legislative hearing, and we clearly have different definitions of what a legislative hearing should look like.

You have invited seven Republican Members to come and talk about bills they have introduced or plan to introduce that will affect Medicare in some way. When we were told of this development, there were requests from staff on whether any Democratic bills on Medicare could be included today and those requests were ignored. In fact, I have a bill on Part D program integrity that is very similar to one presented, but for some reason, that bill was not given any consideration.

So, Mr. Chairman, one bill in particular is quite egregious. It attempts to gut the coverage provisions of the Affordable Care Act in order to provide billions of dollars to private insurance companies. The others are not new ideas from Republicans; they involve allowing individuals to switch to high deductible health plans which do nothing but worsen the risk pool for those in comprehensive MA plans.

Another bill would reinstate the second enrollment period for seniors, an issue that has already been litigated and determined to be confusing and unhelpful to beneficiaries.

And I can go on and on about my concerns here, but most importantly, I wish we could hear from substantive witnesses today on how these bills would weaken—or as the other side claims, strengthen—the MA program, but unfortunately, we were not given that opportunity. So I hope that if the chairman intends to move forward on any of these bills, that the Administration, stakeholders, and Democratic staff would have an opportunity to weigh in. I don't have to remind you that recent history has shown that nothing becomes law out of this committee without bipartisanship.

While the majority of Medicare's 52 million beneficiaries are in the traditional federally administered Medicare program, MA offers beneficiaries an alternative option to receive their Medicare benefits through private health plans. MA has become fairly popular among seniors with more than 1/4 of all beneficiaries now enrolled in such plans across the country.

The ACA included quality improvements of MA plans by rewarding plans that deliver high-quality care with bonus payments.

Incentivizing quality patient care over quantity of services provided is key to improving health outcomes and reducing the rising cost of healthcare. The bottom line is the ACA reined in a program whose costs were excessive and put the program on a more sustainable footing. Since passage of the Affordable Care Act, MA enrollment has increased by nearly $\frac{1}{3}$, premiums have dropped by nearly 10%, and over $\frac{1}{3}$ of MA contracts will receive 4 or more stars, an increase from 28% in 2013.

Despite warning cries to the contrary, the program is stronger than ever. Now, today, we will hear from some witnesses about a study commissioned by the plans themselves. They will claim that CMS' recent proposed cuts could devastate the MA market, but I would like to point out that these are not new cuts; these were expected cuts that bring MA plan payments in line with fee-for-service payments as required by law. And since by law MA plans are paid based on overall growth of Medicare, it is no surprise that when healthcare spending in Medicare slows, payments to MA plans will follow. And we should all think that is a good thing, especially those who continually take aim at the percentage of federal spending on healthcare.

So not only were plans prepared for these reductions, Wall Street doesn't seem to think the outlook is as dire. In fact, some company stocks skyrocketed because the truth is, as more and more baby boomers age into Medicare, and hopefully, unless the Republicans mess it up, a permanent replacement for the SGR is passed into law, the MA program will become even more robust and will continue to be an area of growth for insurance companies.

Regardless of the talking points from the other side and industry, I continue to believe that removing plan overpayments is the right policy for Medicare. To reverse course would raise costs for taxpayers and all Part B beneficiaries, drain from the solvency of the trust fund, and expand beneficiary inequities that disadvantage the overwhelming majority of Medicare beneficiaries who remain in fee-for-service.

So I look forward to hearing from our second panel today, specifically from Ms. Stein and Mr. Van de Water, because a debate about how much we pay private insurance companies is overshadowing some important aspects of CMS' work in protecting beneficiaries. We should all work together to strengthen and improve the program and not weaken it.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Florida, Mr. Bilirakis, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. GUS M. BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. BILIRAKIS. Thank you very much. I appreciate it, Mr. Chairman.

Thanks for holding this important hearing on how to protect Medicare Advantage. My bill, H.R. 3392, the Medicare Part D Patient Safety and Drug Abuse Prevention Act, will reduce fraud and abuse without negatively impacting Medicare beneficiaries by en-

acting cost-saving measures employed not only by TRICARE and the State Medicaid programs but also by private industry.

H.R. 3392 creates a safe pharmacy access program to establish a single point-of-sale pharmacy system for the dispensing of controlled substances for high-risk beneficiaries. This will directly address the issue of doctor and pharmacy shopping where individuals go to multiple locations to fill multiple prescriptions.

I would like to thank my cosponsor, Mr. Ben Lujan, and then I also want to yield now the balance of my time to Dr. Cassidy.

Thank you, Mr. Chairman.

Mr. CASSIDY. Thank you, Mr. Bilirakis. Thank you, Mr. Chairman.

I submit for the record a letter to the CMS that Mr. Barrow and I and over 200 of our congressional colleagues have signed.

We are concerned about the proposed cuts to the MA program and the negative impact it will have on seniors. Over 15 million seniors rely on Medicare Advantage, almost $\frac{1}{3}$ of Medicare beneficiaries. These plans are popular because they have been proven to contain costs and improve enrollee health outcomes by focusing on prevention and disease management. CMS is planning to cut MA plans for overall seniors by 5.9% in 2015. In Louisiana that averages out that the MA beneficiary will have about a \$55 to \$65 cut per month, which of course is \$660 to \$780 per year in higher premiums, higher cost-sharing, and lower benefits for about 200,000 MA beneficiaries in my State.

In response, Members of Congress are coming out of the woodwork to say to CMS stop these cuts, protect Medicare Advantage, protect seniors.

Now, if Mr. Bilirakis will allow me to, I will yield 1 minute to the gentleman from Georgia, Mr. Barrow.

Mr. BARROW. Thank you, Dr. Cassidy, for yielding time, and thank you for your partnership on this issue.

Mr. Chairman, Georgia is home to hundreds of thousands of Medicare Advantage beneficiaries who are worried about the stability of the program. The proposed cuts to Medicare Advantage would amount to a 5.9% cut. These cuts will reduce benefits and increase premiums by \$35 to \$75 per month for our Nation's 15 million seniors with Medicare Advantage. Further cuts to Medicare Advantage would dramatically alter the standard of care that folks have come to rely on. That is why, as of today, 204 of our colleagues have joined Dr. Cassidy and me to warn Administrator Tavenner against these proposed cuts.

Mr. Chairman, thank you for calling this hearing. I look forward to learning much from the witnesses and working with you to strengthen this vital program.

With that, I yield back the balance of my time to Dr. Cassidy.

Mr. CASSIDY. Would the gentleman yield for one second just to welcome our panel and my roommate Mr. Paulsen?

Mr. PITTS. Thank you. And without objection, the letter that Dr. Cassidy submitted will be entered into the record.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. We have two panels today. The first is a Member panel and I will introduce them at this time and they will speak in this order. First, Hon. Erik Paulsen, Member of Congress from

Minnesota; then Hon. Jeff Denham, Member of Congress from California; Hon. Dennis Ross, Member from Florida; Hon. Keith Rothfus, Member from Pennsylvania; and Hon. Jackie Walorski, Member from Indiana.

Thank you very much for coming today. Your written testimony will be made part of the record. You will be each given 5 minutes for your opening statement, so the chair recognizes Mr. Paulsen for 5 minutes.

STATEMENTS OF HON. ERIK PAULSEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA; HON. JEFF DENHAM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; HON. DENNIS ROSS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA; HON. KEITH ROTHFUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA; AND HON. JACKIE WALORSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

STATEMENT OF HON. ERIK PAULSEN

Mr. PAULSEN. Thank you, Mr. Chairman. And, Chairman Pitts and Ranking Member Pallone, I want to thank you for holding this hearing today to ensure that our seniors and their Medicare Advantage (MA) plans are protected from unnecessary cuts.

I have received many calls and emails and letters from my constituents, my seniors in my district, who are concerned about cuts to the Medicare Advantage program and the impact that it could have on their healthcare plans.

The Medicare Advantage program is a resounding success in providing coordinated care for seniors with better quality, more choices, and greater savings for millions of Americans. Over 175,000 seniors in Minnesota are enrolled in an MA plan, including more than 50,000 in my congressional district alone. More than half of Medicare-eligible seniors in my district have opted to enroll in MA plans rather than the traditional fee-for-service system.

Nationwide, millions of Medicare beneficiaries have chosen a Medicare Advantage plan because they value access to better quality of care, innovative services, and additional benefits. The MA program enjoys high patient satisfaction and will reduce the cost of Medicare in the long run by providing evidence-based, coordinated care for our seniors.

Unfortunately, the future viability of the MA program is at risk. The MA program is facing ObamaCare-mandated payment cuts, the health insurance tax, and the coding intensity cut in last year's fiscal cliff deal. The latest threat is the 12% cut in regulatory cuts that have been proposed the last 2 years, including a 6% cut to plans this year. Seniors in my district could pay as much as \$900 more per year as a result of these cuts. Many might lose benefits, and some could lose their plan completely.

The Administration is also attacking Medicare Advantage's innovative delivery system reforms, like in-home risk assessments, that have been absent in fee-for-service. Home risk assessments are clinical encounters in a beneficiary's home designed to prevent, to detect, and to treat chronic diseases to reduce hospital admissions,

decrease readmissions, and improve the overall quality of life for seniors.

And instead of increasing costs for seniors and hindering plans' ability to utilize innovative models of care, Congress should be providing more flexibility to plans and make it easier for seniors to participate in MA-like plans.

That is why I have authoring legislation, Mr. Chairman, H.R. 4177, to allow Medicare beneficiaries to contribute their own money to their Medicare Savings Accounts, these MSAs. Medical Savings Accounts are health savings accounts for Medicare Advantage plans. They allow seniors to utilize money in the accounts to pay for healthcare costs, including some costs that aren't covered by Medicare.

Right now, seniors can't contribute their own money to their MSA like they can to a healthcare savings account. But by giving seniors more flexibility with these accounts, we will empower them to take charge of their own healthcare decisions. And this will strengthen the Medicare Advantage program and it will reduce healthcare costs for seniors and the system in the long-term. I encourage the committee to take a look at this legislation and maybe bring it up for consideration.

Thankfully, Mr. Chairman, there is hope that we can avoid these additional cuts to Medicare Advantage. Over 200 Members, as was mentioned in earlier opening statements, of both parties, including myself, sent a letter to the Administration opposing these proposed cuts. We must protect our seniors and their healthcare plans by opposing these cuts.

I sincerely appreciate the opportunity to testify and commend the committee for their work to protect seniors in Minnesota and around the country.

[The prepared statement of Mr. Paulsen follows:]

Rep. Paulsen Testimony

Energy and Commerce Health Subcommittee

March 13, 2014

Chairman Pitts, Ranking Member Pallone; I want to thank you for holding this hearing today to ensure that our seniors and their Medicare Advantage (MA) plans are protected from unnecessary cuts.

I have received many calls and emails the last two weeks from seniors in my district. They are concerned about the cuts to the Medicare Advantage program and fear the impact it could have on their healthcare plans.

The Medicare Advantage program is a resounding success in providing coordinated care for seniors with better quality, more choices, and greater savings for millions of Americans. Over 175,000 seniors in Minnesota are enrolled in an MA plan, including more than 50,000 in my Congressional district. More than half of Medicare eligible seniors in my district have opted to enroll in MA plans, rather than the traditional fee-for-service system.

Nationwide, millions of Medicare beneficiaries have chosen a Medicare Advantage plan, because they value access to better quality of care, innovative services, and additional benefits. The MA program enjoys high patient satisfaction and will reduce the cost of Medicare in the long run by providing evidence-based, coordinated care for our seniors.

Unfortunately, the future viability of the MA program is at risk. The MA program is facing Obamacare-mandated payment cuts, the Health Insurance Tax, and the Coding Intensity cut in the Fiscal Cliff deal. The latest threat is the 12% in regulatory cuts that have been proposed the last two years, including a 6% cut to plans this year.

Seniors in my district could pay as much as \$900 more per year as a result of these cuts. Many might lose benefits, and some could lose their plan completely.

The administration is also attacking Medicare Advantage's innovative delivery system reforms, like In Home Risk Assessments, that have been absent in fee-for-service. Home Risk Assessments are clinical encounters in a beneficiary's home designed to prevent, detect, and treat chronic diseases to reduce hospital admissions, decrease readmissions, and improve the overall quality of life for seniors.

Instead of increasing costs for seniors and hindering plans' ability to utilize innovative models of care, Congress should provide more flexibility to plans and make it easier for seniors to participate in MA like plans.

That is why I am authoring legislation to allow Medicare beneficiaries to contribute their own money to their Medicare Savings Accounts (MSAs). Medical Savings Accounts are health

savings accounts for Medicare Advantage plans. They allow seniors to utilize money in the accounts to pay for health care costs, including some costs that aren't covered by Medicare. Right now, seniors can't contribute their own money to their MSA like they can to a Health Savings Account. By giving seniors more flexibility with these accounts, we will empower them to take charge of their own healthcare decisions. This will strengthen the Medicare Advantage program and reduce healthcare costs for seniors and the system in the long-term.

I encourage the Committee to take a look at my legislation and bring it up for consideration.

Thankfully, there is hope that we can avoid these additional cuts to Medicare Advantage. 196 members of both parties, including myself, yesterday sent a letter to the administration opposing the proposed cuts. We must protect our seniors and their healthcare plans by opposing these cuts.

I sincerely appreciate the opportunity to testify, and commend the Committee for their work to protect seniors in Minnesota and throughout the country.

Mr. PITTS. The chair thanks the gentleman and now recognizes Mr. Denham, 5 minutes for an opening statement.

STATEMENT OF HON. JEFF DENHAM

Mr. DENHAM. This is straightforward legislation. It will serve to inform the more than 14 million seniors currently enrolled in Medicare Advantage about how the Affordable Care Act is affecting the healthcare plans that they rely on every day.

For over 60,000 seniors who are enrolled in Medicare Advantage in the counties I represent, the Medicare Advantage program has been tremendously successful in improving health outcomes when compared to traditional Medicare fee-for-service. This is because the Medicare Advantage model emphasizes preventive services and managed care to keep beneficiaries healthy.

Medicare Advantage plans also limit out-of-pocket costs, protecting vulnerable seniors from the threat of bankruptcy due to the complicated medical conditions. Maybe this is why a survey of Medicare Advantage beneficiaries found that 90% were satisfied with their coverage, 92% were satisfied with their choice of doctor, and 94% were satisfied with the quality of care received under Medicare Advantage.

The 14 million seniors enrolled in Medicare Advantage plans nationwide deserve to know that the massive government overhaul of our healthcare system was paid for in part by the \$300 billion in cuts to Medicare Advantage plans and a health insurance tax that has just started this year.

The combined effects of these payment cuts and the new health insurance tax are already being felt through cancelled plans, reduced benefits and increased copays. During this year alone, beneficiaries in over 2,000 counties will have fewer plan options compared to 2013 and on average will see their annual costs increased by nearly 10%. Unfortunately, the impact will only grow with time.

As an example, in 2015, seniors in Stanislaus County in my district can expect to pay an additional \$90 per month, or \$1,080 per year for their Medicare Advantage plan. A large percentage of the 33,000 enrollees in Stanislaus County are low-income individuals earning under \$20,000 per year. This rate increase will force them out of participating in the Medicare Advantage program altogether. Did the 111th Congress really mean to cut Medicare Advantage in order to subsidize the Affordable Care Act? Whether Congress meant to or not, seniors have a right to know that these changes are coming so that they can actually plan and budget for these increases that they are going to see.

Mr. Chairman, as you are well aware, there have been at least 37 major alterations to the Affordable Care Act since it was enacted. Some of these were done in cooperation with the Congress, yet on 20 separate occasions, after it became clear that the implementation of the law was failing the American people, the Administration moved unilaterally to change the law. These delays and alterations are proof that the Affordable Care Act is not working as intended. Unfortunately for our seniors in our districts, while the promises of healthcare remain unfulfilled, the cuts and taxes on Medicare Advantage plans required to finance the law are moving forward as scheduled.

Congress must act today to protect the future of Medicare Advantage by repealing the cuts and taxes on the program. This would prevent the immediate erosion of health security for Medicare Advantage beneficiaries while we work to replace the Affordable Care Act with a healthcare reform that puts patients and seniors first.

Until we can enact such legislation, seniors have the right to know why their Medicare Advantage plans are being impacted and I urge this committee to support this bill.

I would also like to thank the 60 Plus Association and the Association of Mature American Citizens for their support of this legislation and would like to submit their letters for the record.

[The prepared statement of Mr. Denham follows:]

- Chairman Upton, Ranking Member Waxman, thank you for this invitation to testify this morning on behalf of my bill, “The Seniors Right to Know Act.”
- This straightforward legislation will serve to inform the more than 14 million seniors currently enrolled in Medicare Advantage (MA) about how the Affordable Care Act is affecting the healthcare plans that they rely on every day.
- For the over 60,000 seniors who are enrolled in Medicare Advantage in the counties I represent the Medicare Advantage program has been tremendously successful in improving health outcomes when compared to traditional Medicare fee-for-service because the MA model emphasizes preventive services and managed care to keep beneficiaries healthy.
- MA plans also limit out-of-pocket costs, protecting vulnerable seniors from the threat of bankruptcy due to complicated medical conditions.
- Maybe this is why a survey of beneficiaries found that:
 - 90% of MA enrollees were satisfied with their coverage
 - 92% were satisfied with their choice of doctor
 - 94% were satisfied with the quality of care received

- The 14 million seniors enrolled in MA plans nationwide deserve to know that the massive government overhaul of our healthcare system was paid for in part by \$300 billion in cuts to MA plans and a health insurance tax that has just started this year.
- The combined effect of these payment cuts and the new health insurance tax are already being felt through cancelled plans, reduced benefits and increased copays.
- During this year alone, beneficiaries in over 2,000 counties will have fewer plan options compared to 2013 and on average will see their annual costs increased by nearly 10%.
- Unfortunately the impact will only grow with time.
- As an example, in 2015, seniors in Stanislaus County in my district can expect to pay an additional \$90 per month, or \$1,080 per year for their MA plan.
- A large percentage of the 31,000 enrollees in Stanislaus County are low-income individuals earning under \$20,000 per year. This rate increase will force them out of participating in the MA program altogether.

- Why are we cutting Medicare Advantage, which is succeeding, to subsidize the Affordable Care Act, which is faltering?
- Mr. Chairman, as you are well aware there have been at least 37 major alterations to the Affordable Care Act since it was enacted. Some of these were done in cooperation with the Congress.
- Yet on 20 separate occasions, after it became clear that the implementation of the law was failing the American people, the Administration moved to unilaterally change the law.
- These delays and alterations are proof that the Affordable Care Act is not working as intended. Unfortunately for seniors in our districts, while the promises of healthcare reform remain unfulfilled, the cuts and taxes on MA plans required to finance the law are moving forward as scheduled.
- Congress must act today to protect the future of Medicare Advantage by repealing the cuts and taxes on the program. This would prevent the immediate erosion of health security for MA beneficiaries while we work to replace the ACA with a healthcare reform plan that puts patients and seniors first.

**Testimony of Representative Jeff Denham: Keeping the Promise: How Better Managing Medicare
Can Protect Seniors**

March 13, 2014

- Until we can enact such legislation, seniors have a right to know why their MA plans are being impacted and I urge the committee to support this bill.
- I would like to thank the 60+ Association and the Association of Mature American Citizens for their support of this legislation and would like to submit their letters for the record.

The 60 Plus Association

515 King Street • Suite 315 • Alexandria, VA 22314
Phone 703.807.2070 • Fax 703.807.2073 • www.60Plus.org

Kill the Death Tax. Protect Social Security and Medicare. Energy Security.

James L. Martin
Chairman

Amy N. Frederick
President

Rep. Roger Zion (R-IN, 1967-75)
Honorary Chairman

Pat Boone
National Spokesman

March 10, 2014

Dear Chairman Pitts,

As Chairman of the 60 Plus Association, representing over 7 MILLION senior citizen activists nationwide, I commend you on convening the hearing entitled "Keeping the Promise: Allowing Seniors to Keep Their Medicare Advantage Plans If They Like Them."

I often weigh in on proposed legislation and changes in regulations on behalf of America's seniors. This time, it is personal, as well. In spite of the overwhelming popularity of Medicare Advantage, some plans have already been cancelled. I speak from experience.

In January, 2010, I switched from a traditional supplemental Medicare plan to Cigna Advantage. Why? Because, like so many other senior citizens on Medicare, I found that these MA plans limited yearly out-of-pocket expenses compared to the enormous financial burden an extended hospital stay could incur under original Medicare. In addition to paying the Medicare Part B premiums, additional enrollment and cost-sharing co-pays may (but didn't always) apply, based upon the plan selected, and many plans offered expanded benefits, including skilled nursing, vision, hearing, dental care and health and wellness programs.

Despite repeated assurances by President Barack Obama that "If you like the insurance you now have, you can keep it...period", I (as did seniors in Massachusetts, California, and other states) received a letter at the end of 2010 that my Medicare Advantage coverage was being terminated. I had to again seek insurance under traditional Medicare.

I liked my Medicare Advantage plan and felt it well met my health care requirements. I couldn't keep it...period.

Of the 41 MILLION senior citizens 65 and older currently participating in Medicare, 14 MILLION of these seniors opted to enroll in the Medicare Advantage program, this private alternative to traditional Medicare, often through a Health Maintenance Organization (65% in 2011) or a Preferred Provider Organization (local PPOs were 18% and Regional PPOs were 9% in 2011). 41% of these Medicare Advantage enrollees have incomes of \$20,000 or less, and 1 in 5 are minorities.

Of the \$556 BILLION total Medicare benefit payments made in 2012, only 22% was for Medicare Advantage care (statistics according to the Kaiser Family Foundation.)

While the Medicare Advantage patch that went into effect on April 19, 2011 BY PRESIDENT OBAMA'S ADMINISTRATIVE ACTION PRIOR TO THE 2012 ELECTIONS temporarily

(over)

delayed some cuts in benefits, over \$300 BILLION of the more than \$715 BILLION cuts to Medicare under Obamacare will come from the Medicare Advantage program and will be funneled into new government programs not for seniors. At that time, Senator Orrin Hatch of Utah (Ranking Republican of the Senate Finance Committee) and Representative Dave Camp of Michigan (Chairman of the House Ways and Means Committee) called this patch "a thinly veiled use of taxpayer dollars for political purposes."

What will be the future impact on Medicare Advantage programs? Those Medicare Advantage programs that survive Obamacare are expected to see cuts in coverage and reduced options for care.

We agree with you, Chairman Pitts, that "The Medicare Advantage program is a lifeline for seniors and those with disabilities and has proven to be a popular and successful model for delivering quality and affordable health care....Broken health care promises have become far too commonplace under this administration. The president needs to keep the promise to America's seniors and disabled."

Indeed, this is another example that "Medicare as we know it" no longer exists, and America's seniors, unfortunately, are being "thrown off the cliff."

Sincerely,



James L. Martin
Chairman
The 60 Plus Association
515 King Street Suite 315
Alexandria VA 22314
703.807.2070
jmartin@60plus.org

The 60 Plus Association is a 20-year-old nonpartisan organization working for death tax repeal, saving Social Security and Medicare, affordable prescription drugs, lowering energy costs and other issues featuring a limited government, less taxes approach as well as a strict adherence to the Constitution. 60 Plus calls on support from over 7 million citizen activists. 60 Plus publishes a newsletter, SENIOR VOICE, and a Scorecard, bestowing awards on lawmakers of both parties who vote "pro-senior." 60 Plus has been called "an increasingly influential senior citizen's group" and the acknowledged conservative alternative to the liberal AARP.

Mr. PITTS. Without objection, so ordered.

The chair thanks the gentleman and now recognizes the gentleman from Florida, Mr. Ross, 5 minutes for an opening statement.

STATEMENT OF HON. DENNIS A. ROSS

Mr. ROSS. Thank you, Chairman Pitts and Ranking Member Pallone, committee, for taking the time today to hold this hearing to highlight the significant threat facing the Medicare Advantage program.

In 2012, healthcare spending in the United States accounted for 17.2% of our Nation's economic output, equal to \$8,915 per person. Mr. Chairman, these statistics tell me that for a country with arguably the best healthcare in the world, we have yet to properly align patient and provider incentives to enable our healthcare system to be cost-efficient, highly accessible, and ultimately to achieve self-sustaining cost-containment with little need for government intervention.

More than 3.5 million Medicare beneficiaries reside in my home State of Florida; 1.2 million of these beneficiaries have chosen a Medicare Advantage plan over Medicare's traditional and more costly fee-for-service structure. In fact, since 2008, the State of Florida alone has seen a 30% increase in the number of Medicare Advantage plan beneficiaries, while currently, 30% of our Nation's Medicare population have opted for a Medicare Advantage plan, serving as a clear testament to the high level of patient satisfaction the program has achieved.

Among the many satisfied Medicare Advantage plan beneficiaries in the State of Florida are Michael and Sandra Cox from my hometown of Lakeland, Florida. Michael and Sandra did what so many Medicare Advantage plan beneficiaries have done since January 1, 2014, writing to their Members of Congress expressing a mix of anger, confusion, and panic at the senseless cuts that have been made to this effective program. Sandra and Michael wrote, "Please explain the logic of the ObamaCare cuts to Medicare Advantage. My husband and I have never experienced such a high level of satisfaction with our health coverage as we have with our Medicare Advantage plan, and all with a much cheaper monthly Premium."

Unfortunately, Michael and Sandra learned on January 1 that the doctors that they had been seeing for more than 10 years were no longer available under the Medicare Advantage plan as a result of the continued cuts to the program. They would face the full out-of-pocket cost should they choose to continue seeing those providers they had come to know over the last 10 years and their health status they treated so well.

Mr. Chairman, was it not the Administration's goal to ensure patients develop a relationship with their provider resulting in better prevention and a more consistent continuum of care?

Unfortunately, these cuts to Medicare Advantage, like so many other healthcare-related actions by this Administration are contradictory to the purported message. Even more baffling, past cuts have already crippled innovative programs like home health visits instituted by Medicare Advantage plan sponsors to ensure our seniors are able to maximize the value of healthcare services they re-

ceive. Going forward, additional cuts of this magnitude will devastate medical innovation in areas like tele-health that show great promise for increasing efficiency and cost-containment in Medicare Advantage and the healthcare system at large.

Overall healthcare spending and utilization habits are a critical threat to America's declining fiscal health. If we are to successfully curb healthcare costs, we must preserve and enhance the Medicare Advantage program because of its proven ability to achieve cost-efficiency while maximizing patient access to high-quality health services and providers.

To be more specific, data collected between 2003 and 2009 showed service utilization rates in areas like emergency department use and ambulatory surgery were 20 to 30% lower among Medicare Advantage beneficiaries than traditional Medicare.

Overutilization of healthcare services, however, is only one facet of healthcare cost growth tempered by the Medicare Advantage plan structure. Although this current Administration has tried to discredit the power of market competition in creating organic, self-sustaining incentives for patients, providers, and insurers alike, the facts always prevail. Artificial market controls put in place by the Federal Government lead to more out-of-control health spending, as we have seen time and time and again.

As far back as 1995, health economists have shown that combining coverage like that offered by Medicare Advantage with appropriate patient incentives leads to an avoidance of excessive doctor visits and tests, as well as more engaged patients seeking the best value for the healthcare service they need.

In this same vein, I was proud to introduce H.R. 4180, the Preserving Health Savings Accounts for Medicare Beneficiaries Act, which would allow for this consistently proven economic strategy for reducing healthcare costs across the spectrum. My legislation would incentivize younger Americans to establish Health Savings Accounts with the promise that upon being Medicare-eligible, they are able to transfer the HSA funds into a Medicare savings account.

Simple enhancements like this one will help both Medicare Advantage and the entire healthcare system achieve organic alignment between insurers and patients and providers and creating a powerful, self-sustaining cost-containment tool. Patients have more control over their healthcare dollars, increasing awareness of reasonable health service costs and quality options, while also actively engaging providers to offer the highest quality service at the lowest reasonable cost in order to earn a patient's business.

Mr. Chairman, this is what value in healthcare looks like. Unfortunately, through continued cuts to the Medicare Advantage program, this Administration will eliminate any possibility we currently have to build upon the Medicare Advantage program's success in curbing healthcare cost.

And I yield back.

[The prepared statement of Mr. Ross follows:]

March 13, 2014
Dennis A. Ross
Energy & Commerce Medicare Advantage Hearing Testimony

Thank you, Mr. Chairman, and to the committee for moving forward on this hearing today to highlight the significant threat facing the Medicare Advantage program.

In 2012 health care spending in the United States accounted for 17.2 percent of our nation's economic output, equal to \$8,915 per person¹. Mr. Chairman, these statistics tell me that for a country that has arguably the best health care in the world, we have yet to properly align patient and provider incentives so our health care system is cost-efficient, highly accessible, and, ultimately, achieves self-sustaining cost-containment with little need for government intervention.

More than 3.5 million Medicare beneficiaries reside in my home state of Florida. 1.2 million of these beneficiaries have chosen a Medicare Advantage plan over Medicare's traditional, and more costly, fee-for-service structure. In fact, since 2008 the state of Florida alone has seen a 30 percent increase in the number of Medicare Advantage plan beneficiaries², while currently, 30 percent of our nation's Medicare population have opted for a Medicare Advantage plan, serving as a clear testament to the high level of patient satisfaction the program has achieved.

Among the many satisfied Medicare Advantage plan beneficiaries in the state of Florida are Michael and Sandra Cox, two of my constituents from Lakeland. Michael and Sandra did what so many Medicare Advantage plan beneficiaries have done since January 1, 2014, writing in to their Members of Congress expressing a mix of anger, confusion, and panic at the senseless cuts that have been made to this effective program. Sandra and Michael wrote, "Please explain the logic of the Obamacare cuts to Medicare Advantage; my husband and I have never experienced such a high level of satisfaction with our health coverage as we have with our [Medicare Advantage] plan, and all with a much cheaper monthly premium..." Unfortunately, Michael and Sandra learned on January 1st that the doctors that they had been seeing for more than 10 years were no longer covered by Medicare Advantage as a result of the continued cuts to the program. As such, they would face the full out-of-pocket cost should they choose to continue seeing the provider that had come to know them, and their health status, so well.

Mr. Chairman, was it not the Administration's goal to ensure patients develop a relationship with their provider, which would lead to better prevention, and a more consistent continuum of care? Unfortunately, these cuts to Medicare Advantage, like so many other actions by this administration against the health care system, are contradictory to the purported message. Even more baffling, these cuts have already crippled innovative programs, like home health visits, instituted by Medicare Advantage plan sponsors to ensure our seniors are able to maximize the value of health care services they receive. Going forward, cuts of this magnitude will devastate medical innovation in areas, like telehealth, that show great promise for increasing efficiency and cost-containment in Medicare Advantage, and the health care system at large.

Overall health care spending and utilization habits are a critical threat to America's declining fiscal health. If we are to successfully curb health care costs, we must preserve and enhance the Medicare Advantage program because of its proven ability to achieve cost-efficiency, while maximizing patient access to high-quality health services and providers. To be more specific, data collected between 2003 and 2009 showed service utilization rates in areas like emergency department use and ambulatory surgery were 20-30 percent lower among Medicare Advantage beneficiaries than traditional Medicare³.

Over-utilization of health care services, however, is only one facet of health care cost growth tempered by the Medicare Advantage plan structure. Although the current administration has tried to discredit the power of market competition in creating organic, self-sustaining incentives for patients, providers, and insurers alike, the facts always prevail. Artificial market controls put in place by the federal government lead to more out of control health spending, as we have seen time and again. As far back as 1995 health economists have shown that combining coverage like that offered by Medicare Advantage, with appropriate patient incentives, leads to an avoidance of excessive doctor visits and tests, as well as more engaged patients seeking the best value for the health care service they need⁴.

In this same vein, I was very proud to introduce H.R. 4180, the Preserving Health Savings Accounts (HSA) for Medicare Beneficiaries Act, which would follow this consistently proven economic strategy for reducing health care costs across the spectrum. My legislation would incentivize younger Americans to establish Health Savings Accounts (HSA) with the promise that upon Medicare eligibility they are able to transfer HSA funds into a Medicare Medical Savings Account (MMSA). Simple enhancements, like this one, will help both Medicare Advantage and the entire health care system achieve organic alignment between insurers, patients, and providers, creating a powerful, self-sustaining cost-containment tool.

Patients have more control over health care dollars, increasing awareness of reasonable health service costs and quality options, while also actively engaging providers to offer the highest quality service at the lowest reasonable cost in order to earn patient's business.

Mr. Chairman, this is what value in health care looks like; unfortunately, through continued cuts to the Medicare Advantage program, this administration will eliminate any possibility we currently have to build upon the Medicare Advantage program's success in curbing health care cost growth.

¹ Centers for Medicare and Medicaid Services, 2012 National Health Expenditures, available online at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>

² Kaiser Family Foundation, State Health Facts; <http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/?state=FL>

³ Bruce E. Landon, Alan M. Zaslavsky, Robert C. Saunders, L. Gregory Pawlson, Joseph P. Newhouse and John Z. Ayanian. Analysis Of Medicare Advantage HMOs Compared With Traditional Medicare Shows Lower Use Of Many Services During 2003-09 *Health Affairs*, 31, no.12 (2012): 2609-2617

⁴ National Center for Policy Analysis, Saving the Medicare System with Medical Savings Accounts; Policy report No.199, available at: <http://heartland.org/sites/default/files/st199.pdf>

Mr. PITTS. The chair thanks the gentleman.

And now the chair is proud to introduce from the State of Pennsylvania Mr. Rothfus and recognize him for 5 minutes for an opening statement.

STATEMENT OF HON. KEITH J. ROTHFUS

Mr. ROTHFUS. Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, thank you for having me here today to testify about H.R. 2453, the Medicare Beneficiary Preservation of Choice Act. I am very pleased to discuss this bipartisan legislation that Congressman Kurt Schrader and I introduced in June of 2013.

Enacting H.R. 2453 is one small fix we can make to Medicare Advantage that can have a big impact on the lives of the seniors utilizing the program in our districts. It simply restores the open enrollment period that existed prior to 2011. This open enrollment period permitted seniors to change Medicare Advantage plans once between January and March if needed. It essentially let seniors test drive the Medicare Advantage plan they would have just selected and change plans if it turns out the plan is not working for them. H.R. 2453 is about choice and fairness for seniors. It is about empowering them to make decisions about their healthcare needs.

Restoring the January to March open enrollment period also makes sense in light of the 2014 Medicare Advantage cuts and the new cuts just proposed by CMS. Last November, the Wall Street Journal reported that one of the Nation's largest Medicare Advantage providers had dropped thousands of doctors from network due to "significant changes and pressures in the healthcare environment."

This is significant because seniors may not have known about the change in time to adjust their decisions during the October to December enrollment period. So if they liked their doctor, seniors may be finding out just now that they cannot keep him or her because they are no longer included in the plan. Passing H.R. 2453 and restoring the 90-day open enrollment period during the first quarter of the year would let seniors react to these types of plan changes, many of which are driven by the harmful cuts to Medicare Advantage that we see happening as the result of the Affordable Care Act.

H.R. 2453 is a patient-centered option for improving Medicare Advantage. It will provide choice for seniors and it will ensure that they have access to the doctors they know and trust. That is why it is supported by America's Health Insurance Plans, the Association of Mature American Citizens, and the 60 Plus Association.

The subcommittee members and its chairman should be thanked for their efforts to strengthen Medicare Advantage. Medicare Advantage delivers quality healthcare and peace of mind with consistently superlative satisfaction ratings from participants. Preserving the program and preventing more cuts to Medicare Advantage is a top priority for me and for the seniors in Pennsylvania's 12th District. Incidentally, in my district, utilization of Medicare Advantage is in excess of 60%, more than double the national rate.

Additional cuts to Medicare Advantage will lead to higher out-of-pocket costs, reduced benefits, and fewer plan options. Instead of

limiting access to a successful program which 9 out of 10 seniors are satisfied with, we should be empowering them to make choices about what best suits them. We should make sure seniors have access to the healthcare providers they know and trust. Instead of cutting Medicare Advantage, we should be finding solutions to lower costs for seniors and sustain the program for the long run.

I had an incident this past Monday with a senior in my district at a restaurant. She was the hostess and she expressed to me a real concern about the cuts to Medicare Advantage personally impacting her. I asked her to call my office and give us more background because I wanted to tell that story here in Washington. And she simply looked at me and said why? So the politicians can accuse me of lying? That is what is happening out there in the country. People are very concerned about what is happening with Medicare Advantage.

I thank the chairman and I yield back.

[The prepared statement of Mr. Rothfus follows:]

**Testimony of the Honorable Keith J. Rothfus [PA-12]
Keeping the Promise: Allowing Seniors to Keep Their Medicare Advantage Plans If They
Like Them
House Committee on Energy and Commerce
Subcommittee on Health
March 13, 2014**

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee. Thank you for having me here today to testify about H.R. 2453, the Medicare Beneficiary Preservation of Choice Act. I am very pleased to discuss this bipartisan legislation that Congressman Kurt Schrader and I introduced in June 2013.

Enacting H.R. 2453 is one small fix we can make to Medicare Advantage that can have a big impact on the lives of the seniors utilizing the program in our districts. It simply restores the open enrollment period that existed prior to 2011. This open enrollment period permitted seniors to change Medicare Advantage plans once between January-March if needed. It essentially let seniors test drive the Medicare Advantage plan they would have just selected and change plans if it turns out the plan is not working for them. H.R. 2453 is about choice and fairness for seniors. It is about empowering them to make decisions about their health care needs.

Restoring the January-March open enrollment period also makes sense in light of the 2014 Medicare Advantage cuts and the new cuts just proposed by CMS. Last November, the *Wall Street Journal* reported that one of the nation's largest Medicare Advantage providers had dropped thousands of doctors from network due to "significant changes and pressures in the health care environment."

This is significant because seniors may not have known about this change in time to adjust their decisions during the October-December enrollment period. So, if they liked their doctor, seniors may be finding out now that they cannot keep him or her because they are no longer included in their plan. Passing H.R. 2453 and restoring the 90-day open enrollment period during the first quarter of the year would let seniors react to these types of plan changes, many of which are driven by the harmful cuts to Medicare Advantage that we see happening as the result of the Affordable Care Act.

H.R. 2453 is a patient-centered option for improving Medicare Advantage. It will provide choice for seniors and it will ensure that they have access to the doctors they know and trust. That is why it is supported by America's Health Insurance Plans, the Association of Mature American Citizens, and the 60 Plus Association.

The Subcommittee members and its Chairman should be thanked for their efforts to strengthen Medicare Advantage. Medicare Advantage delivers quality health care and peace of mind with consistently superlative satisfaction ratings from participants. Preserving the program and preventing more cuts to Medicare Advantage is a top priority for me and for the seniors in Pennsylvania's Twelfth District.

Additional cuts to Medicare Advantage will lead to higher out of pocket costs, reduced benefits, and fewer plan options. Instead of limiting access to a successful program with which nine out of ten seniors are satisfied, we should be empowering them to make choices about what

best suits them.¹ We should make sure seniors have access to the health care providers they know and trust. Instead of cutting Medicare Advantage, we should be finding solutions to lower costs for seniors and sustain the program for the long term.

Again, I thank the Subcommittee for its efforts to improve Medicare Advantage, and I welcome any questions.

¹ National Survey of Seniors Regarding Medicare Advantage Payments – North Star Opinion Research

**One Page Summary of Testimony of the Honorable Keith J. Rothfus [PA-12]
Keeping the Promise: Allowing Seniors to Keep Their Medicare Advantage Plans If They
Like Them
House Committee on Energy and Commerce
Subcommittee on Health
March 13, 2014**

- H.R. 2453, the Medicare Beneficiary Preservation of Choice Act restores the Medicare Advantage open enrollment period that existed prior to 2011.
- The open enrollment period enables seniors to test out their plans for the first three months of the year and make a change to their plan if necessary to better address their health care needs.
- In light of 2014 Medicare Advantage cuts and cuts just announced by CMS, many networks have been narrowed, and seniors may find that doctors are no longer covered by their plan. Restoring the 90-day open enrollment period from January-March will allow seniors to react to these plan changes driven by cuts resulting from the Affordable Care Act.
- Further cuts to Medicare Advantage will result in higher out of pocket costs, reduced benefits, and fewer plan options for seniors. Instead of restricting access to and cutting a successful program, we should be finding solutions to lower costs for seniors and sustain the program for the long term.

Mr. PITTS. The chair thanks the gentleman and now introduces the gentlelady from Indiana, Ms. Walorski. I recognize her for 5 minutes for an opening statement.

STATEMENT OF HON. JACKIE WALORSKI

Ms. WALORSKI. Thank you, Mr. Chairman. Chairman Pitts, Ranking Member Pallone, members of the subcommittee, it is an honor to be here today and I thank you for holding this hearing to examine Medicare Advantage, a vital program that is critical to the health and well-being of many of our nation's seniors.

Over 15 million Americans depend on Medicare Advantage. Through this popular program, seniors and individuals with disabilities are able to select a private health plan of their choice that provides affordable, comprehensive coverage, disease management, and care coordination.

The Affordable Care Act and other regulatory changes have placed significant financial strain on this program, the brunt of which will be borne by the seniors we have promised to protect. Cuts to Medicare Advantage mean higher out-of-pocket costs, a more limited choice of doctors, decreased management of chronic conditions, and decreased coverage for dental and vision services.

In my home State of Indiana, 22% of Medicare-eligible Hoosiers have chosen to enroll in Medicare Advantage, and enrollment in my district is even as high as 27%. This program serves my constituents well, and I am deeply concerned about how cuts will impact seniors in the Hoosier State.

Marcia from Mishawaka told me she is very pleased with her Medicare Advantage program. She loves the quality of the services provided and the prescription drug program that is included. She is worried about the looming cuts because she wants to keep her current doctor. As a senior citizen living on a fixed income, it is important that her premiums remain low and she wonders who will take care of seniors if the cuts continue.

Eighty-seven-year-old Phyllis and her 93-year-old husband Owen like the peace of mind that comes with knowing they will receive excellent care through their current healthcare plan. Back in June, Phyllis fell and broke her hip. She was promptly picked up by an ambulance, admitted to surgery, and received excellent follow-up care in rehab. Her Medicare Advantage plan took care of the costs. Owen had a pacemaker inserted last year, which was also taken care of by his MA plan. Originally, there was no premium for this plan. Now they pay \$34 a month. Although \$34 a month may not seem like much, Phyllis told me if their premiums become too high, they will have to cut back on other necessities. Phyllis and Owen never imagined the Affordable Care Act would negatively impact them, especially when the President said that you can keep your healthcare plan if you like it. But now their healthcare plan is in jeopardy, too.

Medicare Advantage plans are particularly critical to low-income and minority beneficiaries. According to a study by America's Health Insurance Plans, 1 of 5 of those enrolled in Medicare Advantage are minorities and 41% of enrollees have annual incomes of less than \$20,000. Cuts to the program have the potential to disproportionately affect these most vulnerable populations.

That is why I introduced H.R. 4211, the Advantage of Medicare Advantage for Minorities and Low-Income Seniors Act of 2014. This legislation directs the Government Accountability Office to study the number of minority and low-income seniors enrolled in Medicare Advantage and to assess the impacts of Medicare Advantage payment reductions resulting from the Affordable Care Act and other administrative actions.

Studies show that enrollees in Medicare Advantage have lower hospital readmissions, receive higher quality of care, and enjoy better health outcomes as compared to their counterparts in traditional fee-for-service Medicare. Medicare Advantage serves as a vital source of coverage for low-income and minority beneficiaries.

On behalf of my constituents in the 2nd District and all Hoosiers, I look forward to working with both Congress and the Administration to keep the promise to maintain the integrity of Medicare Advantage. Thank you for the opportunity to appear before you this morning.

[The prepared statement of Ms. Walorski follows:]

**STATEMENT OF
THE HONORABLE JACKIE WALORSKI
INDIANA'S SECOND DISTRICT
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES**

MARCH 13, 2014

Chairman Upton, Ranking Member Waxman, Subcommittee Chairman Pitts, Ranking Member Pallone and Members of the Subcommittee, it's an honor to be here today. Thank you for holding this hearing to examine Medicare Advantage, a vital program that is critical to the health and well-being of many of our nation's seniors.

Over 15 million Americans depend on their Medicare Advantage plans.¹ Through this popular program, seniors and individuals with disabilities are able to pick the private health plan of their choice that provides comprehensive coverage, disease management, care coordination, and caps on out-of-pocket health spending.

The Affordable Care Act and subsequent regulatory changes have placed significant and sustained financial pressures on the program, the brunt of which will be borne by those seniors we have promised to care for. These cuts to Medicare Advantage will mean higher out-of-pocket costs, a more limited choice of doctors, decreased management of chronic conditions and decreased coverage for dental and vision services.

¹ Centers for Medicare & Medicaid Services, Medicare Advantage/Part D Contract and Enrollment Data, February 2014, available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/index.html?redirect=/MCRAAdvPartDEnrolData/MCESR/list.asp>.

In my state of Indiana, 22 percent of Medicare-eligible Hoosiers have chosen to enroll in Medicare Advantage, and enrollment in my district is even higher, at 27 percent.² This program serves my constituents well, and I am deeply concerned about what cuts mean for seniors in the Hoosier state.

Marcia from Mishawaka, Indiana told me that she is very pleased with her Medicare Advantage plan. She likes the explanation of benefits in addition to the quality and service of the prescription drug program that is included. She is worried about looming cuts because she wants to keep her current doctor and does not want to have to look for another. As a senior citizen living on a fixed income, it is important that her premiums remain low. She wonders who will take care of seniors if these cuts continue.

Another constituent of mine named Ron is celebrating his 79th birthday this week and is very happy with Medicare Advantage. He told me the program helps with his dental care and pays for things that regular Medicare does not cover. Although the premiums are higher than before, he wants to stay with his current plan. Being able to choose a plan that fits his needs is very important to Ron, and he is not sure he will have that choice in the future.

Eighty-seven-year-old Phyllis and her 93-year-old husband Owen like the peace of mind of knowing they are going to receive excellent care through their current health plan. Back in June, Phyllis fell and broke her hip. She was promptly picked up by an ambulance, admitted to surgery, and received excellent follow-up care in rehab. She did not receive any bill from the surgeon because her Medicare Advantage plan took care of the costs. Owen had a pacemaker inserted last year, which was also taken care of by his Medicare Advantage plan. Originally there was no premium for their plan. Now they pay \$34 a month. Although it may not seem like

² Centers for Medicare & Medicaid Services, Research, Statistics, Data & Systems, February 2014, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research-Statistics-Data-and-Systems.html>.

much, they do not want their premiums to increase further. At their age and on a limited income it is very important that they have dependable, affordable health care, and Phyllis told me if their premiums become too high they will have to cut back on other necessities. Phyllis and Owen never imagined that the Affordable Care Act would negatively impact them, especially when the President said that you can keep your health plan if you like it – but now their plan is in jeopardy, too.

Medicare Advantage plans are particularly critical to low-income, and minority beneficiaries.³ According to a study by America's Health Insurance Plans (AHIP), 1 in 5 of those enrolled in Medicare advantage are minorities. Forty-one percent of enrollees have annual incomes of less than \$20,000. Cuts to the program have the potential to disproportionality affect these populations.

That is the reason why I introduced H.R. 4211, the “Advantage of Medicare Advantage for Minorities and Low-Income Seniors Act of 2014.” This legislation directs the Government Accountability Office to study the number of minority and low-income seniors enrolled in Medicare Advantage, and to assess the impacts of Medicare Advantage payment reductions resulting from the Affordable Care Act and other administrative actions.

Studies show that enrollees in Medicare Advantage have lower hospital readmissions, receive higher quality care, and enjoy better health outcomes as compared to their counterparts in traditional Fee-for-Service Medicare.^{4,5} Medicare Advantage serves as a vital source of coverage for low-income and minority beneficiaries.³ On behalf of my constituents in the

³ “Low-Income & Minority Beneficiaries in Medicare Advantage Plans, 2011,” by AHIP’s Center for Policy and Research, February 2013, available at: <http://www.medicarechoices.org/pdf/LowIncomeMinorityBenMA2011.pdf>.

⁴ Lemieux, J., Sennett, C., Wang, R., Mulligan, T. and Bumbaugh, J. 2012. Hospital readmission rates in Medicare Advantage plans. *The American journal of managed care*, 18 (2), 96-104.

⁵ Ayanian, J. Z., On, B. E., Zaslavsky, A. M., Saunders, R. C., Pawlson, L. G. and Newhouse, J. P. 2013. Medicare beneficiaries more likely to receive appropriate ambulatory services in HMOs than in traditional Medicare. *Health Affairs*, 32 (7), 1228-1235.

Second District and all Hoosiers, I look forward to working with both Congress and the Administration to keep the promise to maintain the integrity of Medicare Advantage. Thank you again for the opportunity to appear before you this morning.

Mr. PITTS. The chair thanks the gentlelady and again thanks the Members for the testimony on your initiatives. We will be happy to work with you on those. Thank you for taking time out of your busy schedules to appear before us today.

There will be no questions. I will excuse panel one at this time and call the second panel to the table and introduce them in the order that they will make presentations.

First, Mr. Frank Little, a Medicare beneficiary with a Medicare Advantage plan; secondly, Dr. Mitchell Lew, CEO and Chief Medical Officer of Prospect Medical Systems; thirdly, Mr. Glenn Giese, Principal, Oliver Wyman Consulting Actuaries; and then Ms. Judith Stein, Executive Director, Center for Medicare Advocacy; and finally, Dr. Paul Van de Water, Senior Fellow, Center on Budget and Policy Priorities.

Thank you all for coming today. Your written testimony will be made part of the record, and we will give each of you 5 minutes to summarize your testimony.

Mr. Little, we will start with you. You are recognized for 5 minutes.

STATEMENTS OF FRANK LITTLE, MEDICARE BENEFICIARY WITH A MEDICARE ADVANTAGE PLAN; MITCHELL LEW, M.D., CEO AND CHIEF MEDICAL OFFICER, PROSPECT MEDICAL SYSTEM; GLENN GIESE, PRINCIPAL, OLIVER WYMAN CONSULTING ACTUARIES; JUDITH STEIN, EXECUTIVE DIRECTOR, CENTER FOR MEDICARE ADVOCACY; AND PAUL N. VAN DE WATER, SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES

STATEMENT OF FRANK LITTLE

Mr. LITTLE. Chairman Pitts and members of the committee, thank you for providing me this opportunity to testify about my personal experience with the Medicare Advantage plan.

My name is Frank Little. I am a retired small business owner from Virginia Beach. I am 70 years old. My wife and I have been enrolled in three different Medicare Advantage plans over the past 5 years. We have received high quality, affordable coverage through our Medicare Advantage plans, but we are concerned that our plan choices are shrinking due to the deep funding cuts in this program.

When I first became eligible for Medicare, I had a choice of four different Medicare Advantage plans that offered prescription drug benefits with no additional premiums. Over the years, uncertainty about the program funding has forced several of these plans to either withdraw from my area or increase premiums.

Today, I am enrolled in a Medicare Advantage plan offered by Humana, which is still the only plan in my area offering a plan that includes prescription drug coverage with no additional premium. I am very satisfied with my Medicare Advantage plan and feel fortunate to have this option.

To help the committee understand why my Medicare Advantage plan is important to me, I want to explain my experience over the last several years. I have had three major medical problems since I retired. I have had open-heart surgery, colon cancer, and a med-

ical procedure on my lungs. I estimate that my medical bills for these conditions have totaled approximately \$750,000 over the last 5 years, and I am pleased to tell you that my Medicare Advantage plans have covered almost all of these expenses. I have paid only a few hundred dollars in out-of-pocket costs. Without my Medicare Advantage plan, I would have faced a high deductible and 20% co-payments if I had not been enrolled in the original Medicare program.

Like many seniors, I live on a fixed income and such high costs would have had a devastating impact on my budget. I also want to emphasize that my Medicare Advantage plan has allowed me to receive high quality care from my personal physician, from outstanding specialists, and from an excellent hospital in my community.

Other seniors in my community have several stories to tell about the quality coverage they receive through their Medicare Advantage plan. We appreciate that our plan provides prescription drug coverage as part of our medical coverage, while also taking care of our expenses to ensure that our out-of-pocket expenses are affordable.

My message to Congress is that I want you to make sure that Medicare Advantage continues to be a strong and adequately funded program. I am asking you to block any additional funding cuts. I am counting on both Congress and the Obama Administration to do the right thing and protect this program from any further funding cuts.

In closing, I want to say that I love my Medicare Advantage plan and I will be deeply disappointed if I lose my plan. Thank you for considering my comments on this important issue.

[The prepared statement of Mr. Little follows:]

**Testimony of Frank Little
on the Medicare Advantage Program
House Energy and Commerce Committee, Subcommittee on Health
March 13, 2014**

Mr. Chairman and members of the committee, thank you for providing me this opportunity to testify about my personal experience with the Medicare Advantage program.

My name is Frank Little, and I am a retired small business owner from Virginia Beach. I am 70 years old. My wife and I have been enrolled in three different Medicare Advantage plans over the past five years. We have received high quality, affordable coverage through our Medicare Advantage plans, but we are concerned that our plan choices are shrinking due to deep funding cuts in this program.

When I first became eligible for Medicare, I had a choice of four different Medicare Advantage plans that offered prescription drug benefits with no additional premium. Over the years, uncertainty about program funding has forced several of these plans to either withdraw from my area or increase premiums. Today I am enrolled in a Medicare Advantage plan offered by Humana, which is

now the only plan in my area offering a plan that includes prescription drug coverage with no additional premium.

I am very satisfied with my Medicare Advantage plan and feel fortunate to have this option. To help the committee understand why my Medicare Advantage plan is important to me, I want to explain my experience over the past several years. I have had three major medical problems since I retired – open-heart surgery, colon cancer, and a medical procedure on my lungs.

I estimate that my medical bills for these conditions have totaled approximately \$750,000 over the years, and I am pleased to tell you that my Medicare Advantage plans have covered almost all of these expenses. I have paid only a few hundred dollars in out-of-pocket costs.

Without my Medicare Advantage plan, I would have faced a high deductible and 20 percent copayments if I had been enrolled in the original Medicare program. Like many seniors, I live on a fixed income and such high costs would have had a devastating impact on my budget.

I also want to emphasize that my Medicare Advantage plan has allowed me to receive high quality care from my personal physician, from outstanding specialists, and from an excellent hospital in my community. Other seniors in my community have similar stories to tell about the quality coverage they receive through their Medicare Advantage plan. We appreciate that our plan provides prescription drug coverage as part of our medical coverage, while also taking care of our expenses to ensure that our out-of-pocket costs are affordable.

My message to Congress is that I want you to make sure that Medicare Advantage continues to be a strong and adequately funded program. I am asking you to block any additional funding cuts. I am counting on both Congress and the Obama Administration to do the right thing and protect this program from any further funding cuts.

In closing, I want to say that I love my Medicare Advantage plan and I will be deeply disappointed if I lose my plan.

Thank you for considering my comments on this important issue.

Mr. PITTS. The Chair thanks the gentleman. I now recognize Dr. Lew 5 minutes for an opening statement.

STATEMENT OF MITCHELL LEW, M.D.

Dr. LEW. Thank you, Chairman Pitts, Ranking Member Pallone, and members of this committee for the invitation to testify today. My name is Dr. Mitchell Lew, and I am part of the CAPG National Board and am pleased to testify on behalf of CAPG, which is the largest association in the country of physician organizations that practice capitated coordinated care.

CAPG members represent 160 medical groups in 20 states and serve 1.2 million Medicare Advantage enrollees. I also address you as a physician who practiced for 10 years before transitioning to a physician executive role 15 years ago. I am CEO of Prospect Medical Group, which is an IPA model with over 4,500 physicians in three States and serving 225,000 members. This model allows us to contract with smaller physician practices under the umbrella of one large organization.

For background, Prospect Medical began in 1985 and we have evolved over the years and we now offer a full range of coordinating care services and programs, and this has resulted in better value to our seniors. It is better care, better health with cost control. Prospect has grown and we now have physicians and hospitals in California, Texas, and Rhode Island.

I come to emphasize the merits of Medicare Advantage and the coordinated care model and the need to preserve the financial support for Medicare Advantage and to continue our investment into the model. Medicare Advantage takes a population-based payment approach, which reduces the high utilization incentives of traditional Medicare. It is value over volume. It is team-based. Physician organizations are structured to provide the best care at the right time in the most appropriate setting. Seniors are managed across an entire continuum of care. They get preventive services, home visits, high-intensity case management for the sickest members, chronic disease management, palliative care. It allows for innovation. Physicians are held to performance standards and they receive quality incentive payments. Social and behavioral services are also delivered in a coordinated manner.

The impact of Medicare Advantage is better care, lower admissions, lower readmissions, lower lengths of stay, better outcomes, higher member satisfaction, more benefits, and higher interest among the new seniors. And that is particularly important for the low-income seniors who like the enhanced benefits and they need the enhanced benefits. Medicare Advantage has grown by 30% over the last 3 years and now 50% of new Medicare enrollees are choosing Medicare Advantage.

The proposed reductions and cumulative cuts pose very serious threats. It will cause an erosion of the coordinated care infrastructure, higher cost-sharing, which will have a profound impact on the lower-income and minority seniors, fewer benefits. These cuts will undermine all of the progress that we have made in developing the healthcare delivery system.

Medicare Advantage should be the infrastructure that all of the newer models in fee-for-service should use to build coordinating

care such as the ACOs and the medical homes. I urge Congress and the Administration to find ways that will strengthen, not cut Medicare Advantage, develop policies that will promote population-based payments.

Medicare Advantage should be the foundation upon which the entire healthcare delivery system builds coordinated care. As you develop Medicare and fiscal policy, I ask that you consider all that Medicare Advantage has to offer and know that additional cuts will have very serious consequences on the coordinated care model and the seniors that it serves. Without Medicare Advantage, we have very little chance to transform our healthcare delivery system.

Thank you very much, Mr. Chairman, and I look forward to your questions.

[The prepared statement of Dr. Lew follows:]



The Voice of Accountable Physician Groups

**Statement of Dr. Mitchell Lew
CAPG – the Voice of Accountable Physician Groups
Before the House of Representatives Energy & Commerce Subcommittee on Health
March 13, 2014**

Thank you Chairman Pitts, Ranking Member Pallone, and Members of the Health Subcommittee for inviting me to testify today.

I am pleased to testify today on behalf of CAPG. CAPG is the largest association in the country representing physician organizations practicing capitated, coordinated care. CAPG members include over 160 multi-specialty medical groups and independent practice associations (IPAs) in over 20 states. CAPG members provide healthcare services to over 1.2 million Medicare Advantage beneficiaries. CAPG members provide comprehensive health care through coordinated and accountable physician group practices. We strongly believe that patient-centered, coordinated, and accountable care offers the highest quality, the most efficient delivery mechanism, and the greatest value for patients. CAPG members have successfully operated under this budget-responsible model for over two decades.

I also address you today as CEO of Prospect Medical Group and as a physician. I have been a physician for 23 years and practiced as an OB-GYN for 10 years. By way of background, Prospect Medical Group was formed in 1985 with an emphasis on arranging exceptional medical care, helping patients get the most value from their healthcare coverage, and offering exclusive services to Prospect members. Prospect Medical Systems, Inc., was created in 1996 to develop, implement and manage a full range of services focusing on the doctor-patient relationship.

915 Wilshire Boulevard, Suite 1620
Los Angeles, CA 90017
Telephone: 213-624-2274
FAX: 213-683-0032
www.capg.org

Prospect has continued to grow to include medical groups and hospitals in California, Texas, and Rhode Island, with plans to continue to expand its geographic reach.

Prospect Medical Group contracts with about 4,500 physicians in what is called the IPA model. This model allows us to contract with small physician practices underneath the umbrella of one larger organization. We serve approximately 225,000 patients and of those, nearly 40,000 are enrolled in Medicare Advantage (MA).

I am deeply concerned about proposed additional cuts to the MA program. My testimony today will outline the benefits of the MA program for seniors; the popularity of this program among the seniors we treat; and how cuts in existing law and regulation combined with proposed cuts through the regulatory process place the coordinated care model and infrastructure at risk. Prospect Medical Group recently joined over 140 other physician organizations in a letter to CMS Administrator Marilyn Tavenner, urging the agency to use its regulatory authority to offset cuts to MA.

As an organization with extensive experience in coordinated care, Prospect Medical Group knows that the way Medicare pays for physician services can either incentivize or disincentivize care coordination. For example, fee-for-service (FFS) Medicare is a volume-based model. Physicians are paid for each service delivered, without an eye toward providing the best value for the patient. There are minimal incentives in FFS Medicare to coordinate among practitioners, provide preventive services, or focus on population health.

In contrast, the MA payment structure when offered through an accountable physician organization, incentivizes value, preventive services, care coordination, and a focus on quality. In MA, physician groups and IPAs are paid capitation (a defined amount for a population). Specifically, the Centers for Medicare & Medicaid Services (CMS) make a defined payment to a health plan for a specific group of beneficiaries. Health plans then pay the physician group or

IPA a defined amount for each enrolled patient over a span of time, usually a percentage of premium and often described as “per-member, per-month” payment. The amount of the payment made directly to the medical group is set in advance and typically paid each month, regardless of the volume of healthcare services provided to an individual patient. The physician organization is operating within a budget and there is no additional money if the physicians run up additional costs. Therefore, the physician groups must hold their employed and contracted physicians to robust performance standards to ensure that the budget is met in a way that improves patient care.

Physician organizations are responsible for paying their employed or contracted physicians. Physician organizations pay their primary care and specialty physicians, and sometimes hospitals, depending on the contract with the MA plan. Physician organizations have the flexibility to tailor these downstream payments to individual physicians to get the desired patient care outcomes. For example, the organization might pay an individual physician subcapitation, a salary, or even FFS in some cases. For example, if a group wants to incentivize higher rates of preventive services, FFS might be the preferred payment mechanism to drive higher rates of these types of services.

The downstream payments also often include payment of incentives for physician performance and outcomes, like quality incentive payments for performance on certain measures. The internal quality measures, evaluations and incentives that physician organizations use tend to be very robust and drive appropriate, high quality care for patients. The internal quality bonus programs are often more rigorous than the MA Stars program; the two are often carefully and strategically interlinked.

I. MA's Population-Based Payments to Physician Organizations Lead to Better Care for Patients

The population-based payment made by the MA plan to the physician group creates numerous benefits that are not seen in the FFS environment. The population-based payment methodology allows us to incentivize a team-based approach. This approach deploys other health care professionals, such as care managers, nurses, social workers, care navigators, pharmacists, and other "mid-level" professionals, as part of a team led by a primary care physician. Each team member practices at the top of his or her license. This team-based approach leads to better outcomes for patients.

These arrangements also incentivize physicians to provide the right care, at the right time in the most cost-effective setting. For example, rather than trying to maximize FFS payments in high-cost settings, when appropriate, patients are safely and appropriately treated in lower cost settings, such as their home. Our experience is that patients have a strong preference to be treated in their homes (and other less-intensive settings) when it is safe and appropriate to do so.

Population-based payments also afford opportunities and incentives to address the environmental, social, and behavioral services that are often omitted in the fee-for-service context. For example, many of our patients need assistance with their mental health needs, commonly depression, in order to be able to truly improve their health status. Our approach takes into account all of these aspects of patient care.

A specific example of these elements coming together to improve patient care comes from Prospect's "Care Plus High Intensity Care" Program. This program is Prospect's medical home model, consisting of proactive management and coordination of services for high-risk patients. The model includes a multi-disciplinary team-based approach, coordinated around the

primary care physician. The Care Plus program engages the patient and, when appropriate, the family or other social support network.

Prospect uses patient stratification techniques to identify patients for the program. We focus on patients with frequent hospital admissions (two or more admissions in 12 months); with frequent emergency department and urgent care visits; with chronic conditions like diabetes or asthma; and high cost utilizers. Once enrolled in the high-intensity care management program, the patient has access to additional services that focus on the patient's healthcare needs. For example, patients enrolled in this program have 24/7 direct telephone access to the care team. The care team identifies specific drivers of hospital admissions and develops specific plans to address the drivers. Patients and their families are engaged in the care plan. The Care Plus program also includes integrated behavioral health management, disease specific action plans, and self-management programs, as appropriate for the patient's specific needs. Within the program, all aspects of the patient's care are coordinated, including ancillary services and physician referrals.

The result of this special attention to patients with the greatest need has had tremendous improvement in quality metrics and also patient quality of life. We have seen a reduction in our senior bed days per thousand from 1,260 to 850 and a reduction in senior admissions per thousand from 244 to 218. We have also seen a reduction in our senior 30-day all inclusive readmission rate from 19% to 13%.

II. Patient Interest in MA is Growing Because of its Positive Results

MA enrollment has grown steadily over the past several years. Recent analysis by the Kaiser Family Foundation shows that 14.4 million Medicare beneficiaries enrolled in MA plans in

2013 – a nearly 30 percent increase over just three years.¹ Although nationally 28% of Medicare enrollees are enrolled in an MA plan, there is broad variation across the states.² In California, nearly 40% of seniors enrolled in Medicare are enrolled in MA. In Rhode Island and Texas, where Prospect Medical also has operations, enrollment in MA is 35% and 27% respectively.³ Importantly, seniors' interest in MA has continued to grow. A recent report by *Health Affairs* showed that more than 50% of new Medicare enrollees are enrolling in MA.⁴

The benefits that flow to patients may be one explanation for the growth in enrollment over the years. Peer reviewed research has consistently shown that MA outperforms FFS Medicare. For example, MA patients are more likely to get preventive screenings, like mammograms, eye tests for diabetes patients and cholesterol screening.⁵ MA beneficiaries have been shown to have lower rates of preventable readmissions than patients in FFS Medicare.⁶

Recent analysis has even shown that the benefits of coordinated care in MA may filter out to the rest of the healthcare system. In some circles it has been described as a halo or spillover effect, where benefits of coordinated care sufficiently improve physician practices such that even patients not enrolled in MA see the benefits of coordinated care.⁷ The study showed that a 10% increase in MA penetration is associated with a 2.4%-4.7% reduction in hospital costs for other patients.⁸

¹ Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, Medicare Advantage, 2013 Spotlight: Enrollment Market Update (June 2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8448.pdf> (accessed Nov. 29, 2013).

² *Id.*

³ *Id.*

⁴ Ann B. Martin, Micah Hartman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team, National Health Spending in 2012: Rate of Health Spending Remained Low for the Fourth Consecutive Year, *Health Affairs*, 33, no. 1 (2014): 67-77.

⁵ Ayanian, John Z. Landon, Bruce E. Newhouse, Joseph P. et. al. *Medicare Beneficiaries More Likely To Receive Appropriate Ambulatory Services in HMOs Than In Traditional Medicare*. *Health Affairs* 32. no. 1228-1235. July 2013/

⁶ Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHA; and Jon Bumbaugh, MA. "Hospital Readmission Rates in Medicare Advantage Plans." *American Journal of Managed Care*. February 2012. Vol. 18, no. 2, p. 96-104.

⁷ Baicker, Katherine. Chernenow, Michael. Robbins, Jacob. *The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization*. National Bureau of Economic Research. May 2013.

⁸ *Id.*

Surveys of Medicare beneficiaries have shown that seniors are highly satisfied with the MA program. A recent research survey showed that 94% of beneficiaries are satisfied with the quality they receive in MA and 90% of beneficiaries are satisfied with the benefits received in their MA plan.⁹

Notably, the MA program has been particularly popular among low-income and minority beneficiaries.¹⁰ 41 percent of Medicare beneficiaries with MA had incomes of \$20,000 or less.¹¹ 64 percent of minority beneficiaries enrolled in MA in 2010 had incomes of \$20,000 or less; 64 percent of African American and 82 percent of Hispanic MA beneficiaries had incomes of \$20,000 or less.¹² In urban areas, like Los Angeles, low-income beneficiaries rely on this program because of the comparatively low out-of-pocket spending and robust health benefits associated with the program. In addition, all MA plans have an out-of-pocket maximum, a protection that is not offered in the FFS program. This helps protect beneficiaries from catastrophic expenses that threaten seniors' financial security. Downward pressure on the MA program increases the chance that these beneficiaries will face higher cost sharing and will make the program a less attractive option.

III. Cuts Place this Popular Program at Risk

Despite its success and popularity, the MA program is under severe stress due to a number of cumulative cuts to the program which, taken together, are having a dramatic and deleterious effect on physician groups in MA. I am concerned that the cuts to the MA program will push both physicians and patients out of the program and back into fragmented FFS models.

Below is an overview of the various legal and regulatory cuts imposed on the MA program *prior* to the CY 2015 Advance Notice. Many of these cuts were aimed at the health

⁹ North Star Opinion Research. "National Survey of Seniors Regarding Medicare Advantage Payments February 6-11, 2013."

¹⁰ America's Health Insurance Plans, Low Income and Minority Beneficiaries in Medicare Advantage Plans, 2010 (May 2012).

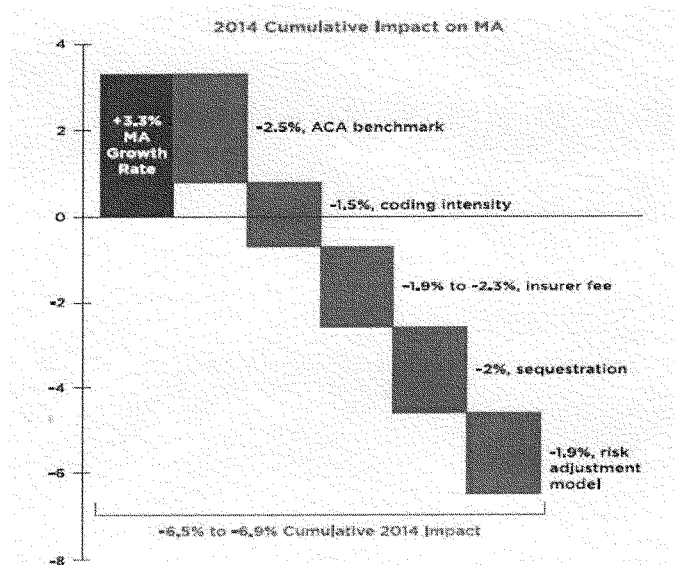
¹¹ *Id.*

¹² *Id.*

plan— that is, a direct reduction to the amount CMS pays to the health plan. However, I want to underscore that these cuts in most cases flow through directly in the form of a reduction to the amount the plan pays to physician organizations that are contracted to receive a percent of the premium. The cuts are passed through without any corresponding decrease in physician responsibilities.

A. A 6.5% Cut in Existing Law and Regulation is Passed Through Directly to Physician Organizations

It is important to understand that deep cuts to the MA program are already taking effect in CY 2014. Although many physician organizations have not felt the full impact of these already required cuts in the first quarter of 2014, the cuts will continue throughout this calendar year and will impact patient care. As shown in the below summary chart, the total impact already required legal and regulatory cuts to MA in CY 2014 is approximately 6.5%.¹³



¹³ Partnership for the Future of Medicare (2014), available at www.futureofmedicare.org.

Below is a brief description of each of these the categories:

- **MA Growth Rate.** In the CY 2014 regulatory process, CMS reversed course on a proposed additional steep reduction to MA rates and instead included a +3.3% MA growth rate. CAPG would like to thank the over 160 Members of Congress for their leadership on this issue.
- **Phase-in of Reduced MA Plan Benchmarks.** The Affordable Care Act revised the methodology and reduced the benchmarks for plan payments. The reductions were designed to bring funding for MA to parity with FFS costs by county. The phase-in of these reductions began in 2012 and continues through 2017. The impact of these changes varies by county, but urban counties, like Los Angeles, are particularly hard hit by this provision. MA payments in Los Angeles will go down to 95% of FFS over a four-year transition period.
- **Coding Intensity Adjustment.** Existing law requires that the Centers for Medicare & Medicaid Services (CMS) increase the coding intensity adjustment on MA plan payments beginning in 2014. This adjustment will reduce MA payments to account for differences in disease coding patterns between MA and FFS Medicare.
- **Insurer Tax.** MA plans are required to pay an annual fee to offset the cost of the ACA's coverage expansion. In some instances, this tax is passed through to physician organizations.
- **Sequestration.** Mandatory across-the-board spending cuts resulting from sequestration result in a two percent reduction to plan payments. In many cases, the plans have passed on the 2% reduction to physician organizations.
- **Risk Adjustment.** CMS has discretion in selecting the risk adjustment model it uses to adjust payments to health plans based on the conditions of the patients. In 2013, CMS announced that it would implement significant changes to the risk adjustment methodology. The impact of these changes on physician organizations varies depending on the patient population the group serves.

B. CY 2015 Advance Notice – Results in over 10% in Cuts to Physician Groups Over 2-Years

On top of the cuts described above, CMS's most recent regulatory proposal would layer an additional programmatic reduction on top of the approximately 6.5% already unfolding on our organization. As shown below, the *average* reduction under the Advance Notice would be 4.79%.¹⁴ Taken together with the average reduction in CY 2014, this means many physician

¹⁴ Gorman Health Group, A Summary and Analysis of the 2015 Draft Call Letter and February 2014 Medicare Advantage Advance Notice (2014).

organizations participating in MA would face an over 10% reduction over the two year period from 2014-2015.

Impact on Medicare Advantage Earnings: ACA plus the February 21 Advance Notice

The following are averages. The actual impact on individual companies will vary, in many cases significantly.

	2015
Advance Notice (February 21, 2014)	
Trends	
Old rates ¹	-3.55%
ACA rates	-1.65%
Average*	-1.90%
Risk adjustment recalibration revisions	0.00%
FFS normalization, change from prior year	3.18%
Total	1.26%

Affordable Care Act and Other Previously Scheduled Changes

Phase-in of new ACA rates*	-2.00%
Coding intensity adjustment	-0.25%

Plan-specific factors

End of Quality Bonus Demonstration, Average* impact: from zero, to 3.5%, to as much as 7% in double bonus counties	-2.00%
Revised health risk assessment rules	-1.00%
Recalculation of county-specific FFS cost estimates*	varies by county
Reassignment of counties to different rate quartiles*	
ACA excise tax on revenues*	-0.8%

Combined Impact, Average*	-4.79%
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¹The old rate trend of -3.55% will only affect MA payments in 21% of US counties, representing 32% of Medicare Advantage members.

*Impact will vary from market to market and plan to plan.

While some of these cuts come from application of existing law and are described above in the discussion of the CY 2014 payment cut, others are newly slated to begin in CY 2015.

- **Rate Book Changes.** Briefly, MA benchmarks are comprised of two components, the “old rates” (benchmark calculated under prior law) and the “ACA rates” (benchmark determined under the ACA). Both are based on the underlying trend in FFS Medicare. In 2015, the MA benchmark represents a blend of these two amounts. Note that the average amount of reduction from the blending of these two rates is -1.9%. However, this is an average and not the actual amount for any particular county in the United States.

In 2014, CMS announced a revised risk adjustment and corresponding cut to MA payment. The new model was to be phased in over a two-year period. In the Advance Notice, CMS proposes delaying full implementation of the new model. This policy, if finalized, would result in a 0% change in CY 2015 and is a positive aspect of the Advance Notice.

Finally, in prior years, CMS has reduced risk scores to compensate for “coding creep” in FFS Medicare. Due to a change in CMS’s methodology in CY 2015, the FFS normalization factor results in a proposed +3.16% improvement in CY 2015. This is a positive development in the rate notice and has the impact of mitigating some of the effect of the negative benchmark updates.

- **Expiration of the 5-Star Quality Demonstration.** The 5-star quality program has been tremendously successful in driving quality at the physician and health plan level. Under existing law, plans that receive 4 or more stars out of 5 stars from the health plan quality rankings will receive bonus payments beginning in 2012. In addition, an existing CMS quality demonstration expanded the quality incentive program to plans with 3 or more stars and expanding the size of the bonuses. In the 5-star quality program, plans receive a single summary score rating on a scale of 1 to 5. A 5-star rating is the highest. The quality measurement program looks at how often enrollees get preventive care (screenings, tests, vaccines); management of chronic conditions; health plan responsiveness; health plan member complaints and appeals; and health plan customer service.¹⁵ The 5-star quality program has driven significant improvement: 52% of plans are now at 4 stars, up from about 37% of plans; and there are now 16 5-star rated plans.¹⁶ The star ratings program has been an effective tool in driving improvements at the health plan and physician group level. Prospect Medical Group is currently ranked between 4 and 5 stars with all of the plans it contracts with.
- **Changes to Health Risk Assessment Rules.** In the CY 2015 Advance Notice, CMS proposes to disregard diagnoses obtained during home visits for the purposes of determining a plan’s risk score. In the Advance Notice, CMS expresses concern that the results from home assessments do not result in treatment and instead are used only to identify and document diagnoses. The result of this proposal is a proposed reduction in MA payments of at least -1%.

¹⁵ CMS, 5-Star Plan ratings, available at <http://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2013-5-Star-Enrollment-Period-Job-Aid.pdf> (accessed Nov. 29, 2013).

¹⁶ Gorman Health Group, Reading the Stars in Medicare in 2014-2015 (Oct. 24, 2013) available at <http://blog.gormanhealthgroup.com/2013/10/24/reading-the-stars-in-medicare-in-2014-2015/> (accessed Nov. 29, 2013).

C. Net Reduction of More than 10% to MA and Physician Organizations Over Two Years

The net effect of these payment policies will be an over 10% reduction over a two-year period. As described above, there is significant variation depending on geographic location and population risk. At Prospect, we expect top line revenue reductions in MA of \$8 million in 2014 and \$7.5 million in 2015. As described above, these legal and regulatory changes are phased in over a series of years, with their full impact not being realized until 2017. This landscape, along with the potential for future cuts to MA, produces a great amount of uncertainty for physician organizations and beneficiaries.

IV. Cuts to MA will Undermine Progress in the Delivery System

I recognize that there are efforts underway to move the Medicare Part B physician payment system to a coordinated care model (e.g., Accountable Care Organizations, bundled payments, and two-sided risk models). As an example, the bi-partisan, bi-cameral legislation to permanently repeal the sustainable growth rate (SGR) includes incentives for physician organizations to enter two-sided risk-bearing models in Medicare Part B.

When properly structured, such models can be successful in improving care coordination for the FFS Medicare population. CAPG members have seen some success with the ACO program in terms of improving outcomes for patients as compared to FFS Medicare beneficiaries without any intervention. However, in nearly every case, this success is directly linked to the organization's experience in the MA program. The MA program provides the infrastructure, things like electronic medical records, care coordination programs, and patient call centers, all of which are factors in improving patient care. Even with the potential for these new delivery models to succeed, the truth remains that MA, with population-based payments made to physician organizations, is the best example within Medicare of a payment structure that provides appropriate incentives to keep patients healthy, coordinate care across specialists

and primary care physicians, and hold physicians and care teams accountable for the quality of services provided.

V. Conclusion – The MA Program Should Be Strengthened, Not Cut

I am very concerned about the proposed additional reductions to the MA program and I urge Congress and the Administration to consider ways that the MA program can be strengthened rather than cut. As Congress considers various ways to improve Medicare Part B, whether it is through existing delivery system reforms (e.g., accountable care organizations, duals demonstrations), or through a reform of the Sustainable Growth Rate formula, the role of MA as the backbone of coordinated care should not be ignored. MA provides a foundation on which the rest of the delivery system can build coordinated care. For example, physician organizations with the capability to accept two-sided risk arrangements, in most cases, have the experience required to be successful because of MA. Furthermore, many organizations that have been successful in deploying care coordination techniques in Traditional Medicare have leveraged off of their MA care processes and infrastructure to effectively do so. Chipping away at the MA program will undermine efforts to make progress in Traditional Medicare.

Instead of cutting MA, Congress and the Administration should develop policies that encourage population-based payments to physician organizations in MA and in Traditional Medicare. This means encouraging the organized practice of medicine; strengthening the coordinated care infrastructure; providing incentives for team-based care and primary care; encouraging physician organizations to develop the ability to accept two-sided risk arrangements. There are existing efforts underway to encourage these types of arrangements, like accountable care organizations and the duals demonstration projects. Congress should keep a watchful eye on these demonstrations to ensure they are appropriately moving toward the goals of coordinated care outlined above.

Thank you for the opportunity to speak to you today. As the Subcommittee continues to consider important Medicare and fiscal policy in the future, I hope you will consider all that the MA program has to offer for seniors. Additional cuts to this program would further undermine the care processes that physician organizations have put in place and will have damaging consequences for the coordinated care model.



The Voice of Accountable Physician Groups

Summary of Statement by Dr. Mitchell Lew, CAPG

Population-Based Payment to Physician Groups in Medicare Advantage (MA). In MA, physician organizations, such as Prospect Medical Group, are paid under a population-based, or capitated, payment model. In this model, the Centers for Medicare & Medicaid Services (CMS) make a payment of premium to health plans. Health plans pay physician groups a defined amount for each enrollee for services over a span of time (e.g., per-member, per-month). Physician organizations then have the flexibility to pay specialists and primary care physicians downstream to incentivize high value healthcare. Population-based payment models are bolstered by robust quality reporting and performance standards, including the MA 5-star program and internal programs.

MA's Payment Structure Leads to Better Care for Seniors. The population-based payment model provides incentives for physician groups to provide better care for seniors. The MA model incentivizes: (1) a team-based approach; (2) physicians to provide the right care at the right time in the most appropriate setting; and (3) physicians to address the patient's total care needs, including social, behavioral and mental health.

Patient Interest in MA is growing because of its Positive Results. MA enrollment is growing because of its benefits to patients. A recent report showed that more than 50% of seniors aging into Medicare are electing MA over traditional Medicare. The benefits to patients, including a greater focus on prevention, focus on care coordination, and lower out of pocket spending are important factors in the enrollment growth.

Existing and Proposed Additional Cuts Place this Popular Program at Risk. The MA program is under stress due to numerous cuts from existing law and regulation and newly proposed cuts. For CY 2014, the combination of legislated and regulatory cuts average about -6.5%. Adding proposed cuts in CY 2015 will bring total program reductions to over 10% for the two-year period. These cuts are unsustainable for physician organizations and will flow through to patients.

Cuts to MA Undermine Coordinated Care Goals. Cutting the MA program will undermine efforts to implement coordinated care and two-sided risk contracting and population-based payments in Medicare Part B. When properly structured, coordinate care models can be successful in improving care for the FFS population. But, in many cases, the success of coordinated care models in FFS is directly linked to the organization's experience in MA. I note that MA remains the best existing example of population-based payment to physician organizations. Further cuts to the MA program will undermine care coordination efforts in other settings.

The MA Program should be Strengthened, Not Cut. Congress and the Administration should consider ways that the MA program can be strengthened. MA serves as the foundation for the development of coordinated care models across the healthcare delivery system. This program should be embraced as a mechanism for improving care and outcomes for seniors and as providing the infrastructure and experience for improvement elsewhere in the delivery system.

915 Wilshire Boulevard, Suite 1620
Los Angeles, CA 90017
Telephone: 213-624-2274
FAX: 213-683-0032
www.capg.org

Mr. PITTS. The chair thanks the gentleman and now recognizes Mr. Giese 5 minutes for an opening statement.

STATEMENT OF GLENN GIESE

Mr. GIESE. Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, thank you for the opportunity to testify. I am Glenn Giese, a senior principal with Oliver Wyman Actuarial Consulting. My testimony today will focus on the findings of a recent analysis by Oliver Wyman commissioned by America's Health Insurance Plans, which estimates the potential impact of funding cuts that would be imposed by Medicare Advantage program by proposed changes to the MA payment methodology in 2015.

Our analysis focused on the combined impact of preliminary payment policies and regulatory changes announced by CMS on February 21, 2014, in its 45-day notice and draft call letter, cuts included in the Affordable Care Act and other legislative provisions addressing MA payments.

Specifically, we identified nine different factors that would impact MA payments in 2015, most of which would reduce payments. A detailed explanation of these factors is outlined in the appendix to my testimony. We have calculated that the projected overall impact of these policies would be to reduce MA payments by an estimated 5.9% in 2015. We note that the impact of these changes on individual plans will vary based on a number of factors, including the geographic area in which the MA organization participates.

We further estimate that the 5.9% funding cut translates into a potential reduction of \$35 to \$75 per month or \$420 to \$900 for the year in funding that will be available to support the benefits of MA enrollees in 2015. These cuts, if implemented, would represent a second consecutive year of deep cuts in MA funding. Due to a combination of legislative and regulatory policies implemented for 2014, MA payments already have been cut by 4 to 6% this year, resulting in cost increases and benefit cuts of \$30 to \$70 per month for beneficiaries. If the new changes proposed by CMS are implemented, the program would be hit by a double-digit cut over just a 2-year period, causing cost increases and benefit reductions that could total as much as \$1,740 per enrollee over 2 years according to our projections.

MA cuts proposed for 2015 could have far-reaching implications for over 15 million seniors and individuals with disabilities who are enrolled in MA plans. In our report we explained that these cuts "could result in a high degree of disruption in the MA market," including the potential for plan exits, reductions in service areas, reduced benefits, provider networks changes, and disenrollment from MA plans.

We further cautioned that the proposed funding cuts would disproportionately affect beneficiaries with low incomes, including the 41% of MA enrollees who have annual incomes below \$20,000. For these beneficiaries, the potential increase in out-of-pocket costs resulting from cuts would constitute a significant burden.

Another serious concern we highlight is that individuals who utilize healthcare services the most would adversely be affected if they lose their MA plans and are forced to move back through the Medicare fee-for-service program with its higher cost-sharing and

lack of coordinated care. This is a particular concern for enrollees in Special Needs Plans that serve beneficiaries who have severe or disabling chronic conditions or who reside in institutions.

For example, Chronic Care SNPs offer services that are tailored to meet the specific medical needs of patients with diabetes, cardiovascular disease, and other conditions. The loss of these specialized services would be a serious blow to beneficiaries whose medical conditions require customized treatments and care.

Thank you again for the opportunity to testify and I encourage the subcommittee and Congress to consider the findings of our analysis as you communicate with CMS about its proposed payment policies and regulatory changes to the MA program for 2015.

[The prepared statement of Mr. Giese follows:]

**The Potential Impact on Medicare Beneficiaries of CMS' Proposed Cuts
to the Medicare Advantage Program in 2015**

by

**Glenn Giese
Senior Principal at Oliver Wyman**

**for the
House Energy and Commerce Committee
Subcommittee on Health**

March 13, 2014

I. Introduction

Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, I am Glenn Giese. I am a fellow in the Society of Actuaries and a Member of the American Academy of Actuaries. I am a Senior Principal with Oliver Wyman Actuarial Consulting and I serve as a Medicare Advantage (MA) actuary for over a dozen plans across the country.

I appreciate the subcommittee's interest in the Medicare Advantage program and how beneficiaries would be impacted by another round of deep funding cuts to Medicare Advantage Organizations (MAOs) in 2015. My testimony will focus on the findings of a recent analysis¹ by Oliver Wyman that estimates the potential impact of the funding cuts that would be imposed on the MA program by proposed changes to the MA payment methodology for 2015.

II. Focus and Key Findings of Oliver Wyman Analysis

Our analysis, which was commissioned by America's Health Insurance Plans (AHIP), focused on the combined impact of preliminary payment policies and regulatory changes announced by the Centers for Medicare & Medicaid Services (CMS) on February 21, 2014 in its "Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and Draft 2015 Call Letter", cuts included in the Affordable Care Act (ACA), and other legislative provisions addressing MA payments.

¹ 2015 Advance Notice: Changes to Medicare Advantage Payment Methodology and the Potential Effect on Medicare Advantage Organizations and Beneficiaries, Oliver Wyman, February 27, 2014

Specifically, we identified nine different factors that would impact MA payments in 2015, most of which would reduce payments. As shown in the table below, we have calculated that the projected overall impact of these policies would be to reduce MA payments by an estimated 5.9 percent in 2015. A detailed explanation of these policies and the estimates shown below can be found in Appendix A, which contains the full text of our analysis. We note that the impact of these changes on individual plans will vary based on a number of factors, including the geographic area in which the MAO participates.

Estimated Reduction in 2015 for MAOs	
	Reduction (%)
ACA quartile impact for 2015	-2.4%
Change in plans' star rating for 2015	0.4%
Elimination of bonus for 3.0 and 3.5 stars for 2015	-1.9%
Elimination of applicable amount bonus	-0.1%
Ratebook change for 2015	-1.9%
Projected insurer fee for 2015	-0.8%
Coding intensity change for 2015	-0.25%
Risk score normalization factor for 2015	3.2%
*Elimination of home assessment visit diagnoses	-2.0%
Total Reduction for 2015	-5.9%

We further estimate that the 5.9 percent funding cut translates into a potential reduction of \$35-\$75 per month – or \$420-\$900 for the year – in the funding that will be available to support the benefits of MA enrollees in 2015. These cuts, if implemented, would represent the second consecutive year of deep cuts in MA funding. Due to a combination of legislative and regulatory policies implemented for 2014, MA payments already have been cut by 4-6 percent this year, resulting in cost increases and benefit cuts of \$30-\$70 per month for beneficiaries. If the new changes proposed by CMS are implemented, the program would be hit by a double-digit cut over

just a two-year period, causing cost increases and benefit reductions that could total as much as \$1,740 per enrollee over two years, according to our projections.

III. Impact of Proposed MA Cuts on Beneficiaries

The MA cuts proposed for 2015 could have far-reaching implications for the over 15 million seniors and individuals with disabilities who are enrolled in MA plans. In our report, we explain that these cuts “could result in a high degree of disruption in the MA market,” including the potential for plan exits, reductions in service areas, reduced benefits, provider network changes, and disenrollment from MA plans. Such disruptions occurred once before in recent history when Medicare health plan enrollment declined from 6.2 million in 1999 to 4.7 million in 2003, as numerous health plans were forced to exit the market due to deep funding cuts in what was known at that time as the Medicare+Choice program.

We further caution that the proposed funding cuts would disproportionately affect beneficiaries with low incomes, including the 41 percent of MA enrollees who have annual incomes below \$20,000. For these beneficiaries, the potential increase in out-of-pocket costs resulting from the cuts would constitute a significant burden.

Another serious concern we highlight is that individuals who utilize health care services the most would be adversely affected if they lose their MA plans and are forced to move to the Medicare fee-for-service (FFS) program with its higher cost sharing and lack of coordinated care. This is a

particularly serious concern for enrollees in Special Needs Plans (SNPs) that serve beneficiaries who have severe or disabling chronic conditions or who reside in institutions. For example, Chronic Care SNPs offer services that are tailored to meet the specific medical needs of patients with diabetes, cardiovascular disease, and other conditions. The loss of these specialized services would be a serious blow to beneficiaries whose medical conditions require customized treatments and care.

From a broader perspective, disruptions to the MA program would be harmful to beneficiaries who would be at risk of losing access to disease and care management programs and other innovative services commonly offered by MA plans. These initiatives focus on preventing illness, managing chronic conditions, improving health status, and employing best practices to swiftly treat medical conditions as they occur, rather than waiting until they have advanced to a more serious stage. The success of these strategies can be seen in the track record of MA plans in reducing preventable hospital readmissions and providing better health outcomes for enrollees.

IV. State-by-State Impact of the Proposed MA Cuts

To provide additional insights into the impact of the MA cuts proposed for 2015, we have calculated state-by-state estimates across the nation:

Estimated State-by-State Impact of Proposed Reductions to 2015 Medicare Advantage*

State	MA Enrollment (February 2014)	Estimated Average PMPM Reduction
Alabama	221,361	\$65-\$75
Alaska	84	NA
Arizona	400,691	\$35-\$45
Arkansas	108,822	\$45-\$55
California	2,054,840	\$45-\$55
Colorado	238,438	\$35-\$45
Connecticut	146,284	\$15-\$25
Delaware	12,714	\$25-\$35
District of Columbia	4,056	NA
Florida	1,436,678	\$35-\$45
Georgia	404,645	\$45-\$55
Hawaii	107,960	\$65-\$75
Idaho	81,748	\$45-\$55
Illinois	317,787	\$25-\$35
Indiana	247,109	\$45-\$55
Iowa	69,450	\$35-\$45
Kansas	59,718	\$45-\$55
Kentucky	199,610	\$45-\$55
Louisiana	213,923	\$55-\$65
Maine	58,278	\$25-\$35
Maryland	44,862	\$25-\$35
Massachusetts	217,282	\$35-\$45
Michigan	547,989	\$15-\$25
Minnesota	175,858	\$25-\$35
Mississippi	71,044	\$35-\$45
Missouri	287,333	\$45-\$55
Montana	31,611	\$5-\$15
Nebraska	33,650	\$35-\$45
Nevada	136,323	\$35-\$45
New Hampshire	15,991	\$35-\$45
New Jersey	216,981	\$65-\$75
New Mexico	107,265	\$55-\$65
New York	1,145,899	\$65-\$75
North Carolina	476,615	\$55-\$65
North Dakota	2,182	\$5-\$15
Ohio	779,401	\$55-\$65
Oklahoma	107,817	\$45-\$55
Oregon	305,428	\$35-\$45
Pennsylvania	960,598	\$45-\$55

State	MA Enrollment (February 2014)	Estimated Average PMPM Reduction
Puerto Rico	536,234	\$55-\$65
Rhode Island	70,346	\$5-\$15
South Carolina	193,541	\$45-\$55
South Dakota	8,960	\$5-\$15
Tennessee	378,156	\$25-\$35
Texas	967,287	\$65-\$75
Utah	107,408	\$45-\$55
Vermont	8,673	\$25-\$35
Virginia	181,670	\$45-\$55
Washington	328,801	\$55-\$65
West Virginia	98,900	\$35-\$45
Wisconsin	315,038	\$25-\$35
Wyoming	2,087	\$35-\$45
Grand Total	15,245,426	\$45-\$55

* Note: Estimates reflect combined impact of the proposed FFS trend and growth rate in the Advance Notice, ACA phase-in, change in star ratings on benchmarks and rebates, the end of the Quality Bonus Payment Demonstration, projected increase in the health insurance tax, the change in the FFS Normalization Factor, the change in the coding intensity adjustment, and the elimination of home assessment visit diagnoses. Calculation of ACA phase-in component includes IME reductions in high IME counties pursuant to previous law. Does not include impact of CMS' rebasing of county fee-for-service amounts because CMS does not release county rates until final MA rates are announced in April.

V. Conclusion

Thank you again for this opportunity to testify. I encourage the subcommittee and Congress to consider the findings of our analysis as you communicate with CMS about its proposed payment policies and regulatory changes to the MA program for 2015.

Mr. PITTS. The chair thanks the gentleman and now recognizes Ms. Stein 5 minutes for an opening statement.

STATEMENT OF JUDITH STEIN

Ms. STEIN. Mr. Chairman Pitts, Ranking Member Pallone, and distinguished members of the subcommittee, thank you for inviting me to testify. I am Judith Stein, founder and Executive Director of the Center for Medicare Advocacy. I have dedicated my legal career to representing Medicare beneficiaries exclusively since 1977. The Center is a private, nonprofit organization based in Connecticut and Washington, D.C., with offices throughout the country. We responded to over 7,000 calls and emails from Medicare beneficiaries and their families each year.

Medicare beneficiaries have had the option to enroll in private health plans since the '70s. The Medicare private plan option, now called Medicare Advantage, prior Medicare Plus Choice, was supposed to provide equal or better coverage for beneficiaries at a lower cost than traditional Medicare. Unfortunately, that has not been the case. As you know, in fact on average, private MA plans, Medicare Advantage, are paid significantly more than it would cost to provide similar coverage in traditional Medicare.

Now, we recognize that MA plans can be a viable option for some enrollees, but I must remind the committee that the vast majority, 36 million or more older and disabled people, are enrolled in traditional Medicare, which is no longer a fee-for-service program, and 50% of all Medicare beneficiaries have incomes under \$23,500 a year.

At the Center, we regularly hear from families and individuals who have had problems with their MA plans. One of the most frequent issues we encounter concerning MA coverage relates to post-acute care. For example, over the last year the Center has received complaints from across the country about MA plans that have denied coverage for skilled nursing facility care despite the fact that the individuals at issue were receiving nutrition through feeding tubes, which under federal regulations and common sense is a skilled service. We have heard this from Ohio, Pennsylvania, Minnesota, and of course Connecticut.

In fact, one of the beneficiaries who called us, or the family did, was granted coverage on appeal but the MA plan actually appealed that case to federal court. And we, a nonprofit that is not paid by our clients, had to go to federal court to make sure that that individual and the others like him in that MA plan would get coverage and care.

These issues are not new and occurred even at the height of MA overpayments when plans were paid at an average of 114% of the amount traditional Medicare would spend on a similar individual. In 2009, for example, the Center had to take another case to federal court in order to obtain coverage for an individual receiving tube feeding. But the MA plan was so determined to deny coverage it continued that case into federal court in Minnesota.

One of the most important health considerations for individuals is the ability to choose one's doctors and healthcare providers. This is the choice that people really care about. By design, as you know, MA plans contract with a limited network of providers to care for

enrollees. Some coordinate care, but that is far from the normal course we have found with their beneficiaries over the 30 plus years I have done this work.

For example, a Connecticut resident was referred to us by his Congressman because he had almost \$100,000 in outstanding medical bills for his recently deceased wife that would have been covered had he been in traditional Medicare. That is because he traveled to Florida to be with his daughter where his wife fell. And while her fractured hip was taken care of and paid for by the plan, it turned out she had a brain tumor, and all the services related to the brain tumor were not covered by the MA plan.

Sometimes Medicare Advantage enrollees face barriers close to home. When MA plans change their provider networks, as they often do annually, enrollees often have to make sure that their doctors will be in the plan in the coming year. As you may know, the largest plan in our State of Connecticut and in New York, Ohio, and Florida cut many, many providers, 2,250 doctors and healthcare facilities in Connecticut alone, including Yale New Haven Hospital where my mother, who is on traditional Medicare, recently had urgently needed neurosurgery, which she would not be able to have if she was in a Medicare Advantage plan. Neither physicians nor Medicare patients in that plan, the largest in Connecticut—and in Ohio, Florida, New York—were given adequate notice regarding these extraordinary provider cuts.

In addition to the concerns raised for Medicare beneficiaries by MA networks, too many plans fail to provide adequate coverage and access to care when enrollees are seriously ill. While I am grateful for the care that my co-presenter has received from his MA plan, too often we find that when people become truly ill or injured, they are less satisfied with their MA plan. That has been the case with my uncle just this year, my mother's brother, who is 92 and has been in an MA plan all these years despite my protestations. He is not receiving coordinated care or the care he needs.

Mr. PITTS. Can you wrap up, please?

Ms. STEIN. Instead of focusing on how much Medicare payments are being cut, which is not really a cut, Congress should focus on making sure they provide what we are paying for. It is simply unfair to ask beneficiaries and taxpayers to shoulder extra payments to private plans that truly don't provide uniformly better value. Enrollees in poor health often receive less coverage and all have less options of providers.

Thank you.

[The prepared statement of Ms. Stein follows:]



Testimony of Judith A. Stein
Executive Director, Center for Medicare Advocacy, Inc.

United States House of Representatives
Energy & Commerce, Subcommittee on Health

"Keeping the Promise:
Allowing Seniors to Keep Their Medicare Advantage Plans
If They Like Them"

March 13, 2014

I. Introduction

Chairman Pitts, Ranking Member Pallone, and distinguished members of the Subcommittee on Health, thank you for inviting me to testify at this hearing. I am Judith Stein, founder and executive director of the Center for Medicare Advocacy (the Center). The Center is a private, non-profit organization based in Mansfield, Connecticut with offices in Washington, DC and throughout the country.

The Center provides education and legal assistance to advance fair access to Medicare and quality healthcare for Medicare beneficiaries throughout Connecticut and the United States. We represent Medicare beneficiaries throughout the state, respond to over 7,000 calls and emails annually, host websites, webinars, and publish a weekly electronic and a quarterly print newsletter. The Center also provides materials, education, and expert support for Connecticut's State Health Insurance Assistance Program (SHIP), known as CHOICES.

II. Our Experience Assisting MA Plan Enrollees

Medicare beneficiaries have had the option to enroll in private health plans since the 1970s. The Medicare private plan option, now called Medicare Advantage (MA), was supposed to provide equal or better coverage for beneficiaries at a lower cost than traditional Medicare. Unfortunately this has not been the case. In fact, on average, private MA plans are paid significantly more than it would cost to provide similar coverage in traditional Medicare. And, in our experience, while MA plans work for some individuals, we regularly hear from MA plan enrollees who have difficulty accessing coverage that their plans are required to provide.

We recognize that MA plans can be a viable option for some enrollees. As a beneficiary advocacy organization, however, we are rarely contacted by individuals who are happy with their

plans. Instead, we regularly hear from individuals and their families who are having trouble accessing services through their MA plans. For many of these individuals, their MA plans worked fine while they were relatively healthy, but once they required more intensive medical services, or needed to see a particular provider, their MA plan became a barrier to care.

The following are some examples of the concerns about Medicare Advantage my organization hears from MA enrollees and their families.

Accessing Medicare-Covered Services

One of the most frequent issues we encounter concerning MA coverage relates to post-acute care. In the skilled-nursing facility setting, beneficiaries are denied coverage, even when they are receiving daily services that are defined as “per se skilled care” in federal regulations – and thus should trigger Medicare coverage.¹ For example, over the last year, the Center has received complaints from across the country about one large MA plan that has been denying coverage for skilled nursing facility (SNF) care, including for individuals receiving their nutrition through a feeding tube. For example:

- In November 2013 we assisted the son of an MA enrollee in Ohio who had been in a skilled nursing facility for a little over a month. She had been receiving daily therapy (speech/physical/occupational) and getting at least 80% of her daily calories through a feeding tube. During that time, her MA plan twice moved to deny coverage of skilled care, and the beneficiary appealed twice and won two reconsiderations;
- In October 2013, staff from a SNF in Pennsylvania contacted us concerning a resident, an MA enrollee, who in their view clearly met Medicare coverage guidelines for skilled

¹ See, e.g., 42 CFR §409.33(b).

care, including the requisite level of tube feeding, but her MA plan issued a coverage denial, in part, stating that the resident could get the same care at home.

Our experience is echoed elsewhere. For example, in late 2013, Minnesota's Attorney General (AG) asked CMS to investigate plans offered by one MA carrier and presented numerous affidavits of beneficiary complaints, including allegations that the insurer "denied reimbursement for services that it is required to cover for all Medicare beneficiaries—including diagnostic ultrasounds, mammograms and care in a skilled-nursing facility for a stroke patient"; in addition, the AG alleged that the plan "created confusion by not adequately disclosing which providers were in-network and does not comply with required appeals processes."²

These issues are not new, and occurred even at the height of MA overpayments, when plans were paid at an average of 114% of the amount traditional Medicare would spend on an individual. In 2009, for example, the Center had to take one appeal all the way to federal court in order to obtain coverage for an individual receiving daily enteral feeding – a service that is a per se skilled service, and therefore covered, under federal Medicare regulations. In this case, the Center won coverage at the highest level of the Medicare administrative appeal system, but the MA plan was so determined to deny coverage, it appealed to federal court.³

² Quote from Kutscher, Beth, "Minnesota Wants CMS to Investigate Humana's Medicare Advantage Plans" (October 18, 2013), *Modern Healthcare*; also see Press Release, Minnesota Attorney General's Office (October 18, 2013), available at: <https://www.ag.state.mn.us/Consumer/PressRelease/20131018HumanaMedicare.asp>.

³ *United Healthcare Insurance Co. d/b/a Evercare v. Sebelius & Starkowski*, April 5, 2011 No. 09-cv-1927-MJD-JSM (D.Minn.), filed July 23, 2009. The Center represented the Connecticut Commissioner of the Dept. of Social Services. On January 7, 2011, the district court granted the defendants' motions for summary judgment and denied the plaintiff Part C plan's cross-motion, thereby affirming the decisions in favor of the beneficiary by the ALJ and the Medicare Appeals Council. — F.Supp.2d —, 2011 WL 70626 (D.Minn. 2011). The court determined that, on the facts presented, the enteral feedings were skilled services and thereby covered by Medicare. The plan did not appeal.

In 2013, the Center conducted Medicare training for over 100 home health agency representatives in Connecticut. There was general agreement among those present that it is more difficult to obtain Medicare coverage for necessary home health care from MA plans than from traditional Medicare.

Choice of Provider

One of the most important health care considerations for an individual is the ability to choose one's doctor(s) and other health care providers. This is the choice that people really care about. By design, however, MA plans contract with a limited network of providers to care for their enrollees. Networks are supposedly designed to coordinate care and control costs; whether they do so or not, they do limit the choice of doctors and health care providers. MA networks can also cause problems for enrollees who seek health care outside their geographic area – and even for some close to home.

When plan enrollees are out of their plan's service area and require urgent or emergency services, their MA plan is required to provide coverage. But problems still arise. For example:

- A Connecticut resident was referred to the Center by his Congressman because he had almost \$100,000 in outstanding medical bills for his recently deceased wife. He and his wife were enrolled in an MA plan. When they traveled to see their daughter in Florida, his wife fell and broke her hip. Emergency care for the broken hip was covered by their MA plan but other necessary care was not. As it turned out, his wife fell because she had a brain tumor, which they did not know about. She required a great deal of care, far away from home, including for myriad complications from cancer treatment. This all resulted in \$100,000 in unpaid bills – which would have been covered by traditional Medicare.

Sometimes Medicare Advantage enrollees face barriers to care even within the plan's service area, including due to provider network changes and limitations. When MA plans change their provider networks, as they often do each year, it can be highly disruptive to plan enrollees. For example, for 2014, Medicare beneficiaries enrolled in the largest MA plan in my home state of Connecticut experienced major disruptions in access to care. In late 2013 United Healthcare jettisoned approximately 2,250 providers and healthcare facilities from its Connecticut Medicare Advantage network, including Yale New Haven Hospital. In a small state like Connecticut, that's a very large number – about one physician or hospital or nursing home, or other healthcare provider lost, for every 260 Connecticut Medicare beneficiaries. Neither physicians nor Medicare patients were given adequate notice of this extraordinary decision by United. In fact, it was only as the 2013 Medicare enrollment period came to a close, that people enrolled in the United Healthcare MA plan learned that their doctors and/or hospital would not be available to them in United's reduced Medicare Advantage network in 2014. Many others did not learn until after the new year, others will not learn until they seek medical care during 2014, only to find their doctor or other healthcare provider is no longer in their Medicare plan.

- As I testified at a Senate Aging Committee hearing recently,⁴ clients of the Center are an example of individuals who learned about the United Healthcare network cut only when health care was urgently needed. Susan W. called us on behalf of her parents, who are both in their 80s. Mr. W. had a stroke in 2013 with bleeding in his brain. He was helicoptered from his local hospital to Yale New Haven due to the complexity of his condition. Now he is finding his medical and rehabilitation needs severely limited and

⁴ Senate Aging Committee hearing "Medicare Advantage: Changing Networks and Effects on Consumers" (Hartford, CT, 1/22/14), see: <http://www.aging.senate.gov/hearings/medicare-advantage-changing-networks-and-effects-on-consumers>.

further complicated by United's Medicare Advantage network cuts. His long-time primary care doctor and his local hospital are no longer in United's Medicare Advantage network. He must travel farther to another, unknown hospital and find a new doctor.

Most importantly, he cannot obtain the nursing care or rehabilitation he needs at the nursing home closest to his wife and community since it too has been cut from United's Medicare Advantage plan. As with many Medicare beneficiaries, Mr. W. had long been in traditional Medicare with supplemental Medigap coverage, but switched to the United Medicare Advantage plan in 2011 because it was less expensive. This worked until he became ill and United exercised its business prerogative to severely reduce providers from its Medicare Advantage network. We know we will hear from many other people like Mr. W. as the year proceeds and they need health care but find their providers are no longer in the United Medicare Advantage network.

Access to Quality Care for All Enrollees

In addition to concerns raised for Medicare beneficiaries by MA networks, too many plans fail to provide adequate coverage and access to care when enrollees are seriously ill or injured. While beneficiaries who are relatively healthy may fare well in MA plans, that is often not true for sicker enrollees. For example, in 2012, the Centers for Medicare & Medicaid Services released a report concluding that disenrollment by individuals from MA plans back to traditional Medicare "continues to occur disproportionately among high cost beneficiaries, raising concerns about care experiences among sicker enrollees and increased costs to Medicare."⁵

⁵ Gerald F. Riley, "Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for-Services", CMS, Medicare & Medicaid Research Review (MMRR) Vol. 2 No. 4 (2012), available at: http://www.cms.gov/mmrr/Downloads/MMRR2012_002_04_A08.pdf.

III. The Affordable Care Act Has Improved Consumer Protections and Reins in Medicare Advantage Overpayments

Improvements in Consumer Protection

The Affordable Care Act of 2010 (ACA) has strengthened both the Medicare program in general, and the Medicare Advantage program in particular. While moving the Medicare program towards providing high value care and rewarding quality, ACA implemented a number of provisions improving the MA program for beneficiaries, including:

- Limiting the ability of MA plans to charge higher cost-sharing than traditional Medicare for certain services;
- Instituting a medical loss ratio (MLR) which requires plans to ensure that they spend at least 85% of their income from premiums and Medicare payments on patient care, instead of profits, marketing, executive salaries and other administrative costs; and
- Adding quality improvement initiatives, including tying payment bonuses to quality star ratings.

CMS has also strengthened consumer protections by instituting annual maximum out-of-pocket (MOOP) requirements and improving beneficiary choice by consolidating plans with duplicative benefits and low-enrollment.

Reining in MA Overpayments

Perhaps most significantly, the Affordable Care Act has put the Medicare program on a more sound fiscal footing by reining in overpayments to MA plans over a period of years. The Balanced Budget Act of 1997 (BBA), authorized private plan options in a new Medicare Part C program known as "Medicare+Choice." These private plans were paid 95% of average

traditional Medicare costs in each county.⁶ The Medicare Modernization Act of 2003 (MMA) revised the Part C program, changing the program name to Medicare Advantage, and developing a new payment system.⁷

The MA payment system passed in 2003 led to Medicare paying private MA plans in virtually every county across the country *more* than the costs for the same beneficiary in traditional Medicare between 2006 through 2010.⁸ According to research at George Washington University,⁹ in 2009 per-enrollee payments were, on average, 13% higher for MA plans than for traditional Medicare; a total of \$12.7 billion in overpayments in 2009 alone. Further, in 2009 the costs of extra Medicare payments to MA plans over the costs in traditional Medicare were projected by the Congressional Budget Office (CBO) at more than \$150 billion over 10 years.¹⁰

In an effort to rein in overpayments to MA plans, ACA has begun the process of bringing MA payments closer to what traditional Medicare spends on a given beneficiary. By 2017, extra payments to MA plans will be reduced to a national average of 101% of the costs of traditional Medicare.¹¹ So, even when the ACA payment adjustments to MA plans are fully implemented, MA plans will, on average, *still* be paid more than traditional Medicare costs.

Both Medicare costs and national health expenditures have grown at historically low rates over the last several years.¹² Slower cost growth in Medicare is factored into payment rates for

⁶ See, e.g., Kaiser Family Foundation, Medicare Advantage Fact Sheet (November 2013), available at: <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>.

⁷ Id.

⁸ See, e.g., Senate Aging Committee, 1/22/14 hearing "Medicare Advantage: Changing Networks and Effects on Consumers", testimony of Prof. Brian Biles, available at: www.aging.senate.gov/imo/media/doc/Biles_1_22_14.pdf.

⁹ Id.

¹⁰ Id.

¹¹ Id. For more information about MA payment, see, e.g., MedPAC "Medicare Advantage Payment Basics" October 2013 http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_MA.pdf.

¹² See, e.g., CMS Press Release 1/6/14: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-06.html>.

Medicare Advantage, including the estimated per-beneficiary cost of providing Medicare services in traditional Medicare. Thus, as cost growth in Medicare slows, payment increases to MA plans also slow, to reflect actual costs. This slower growth in Medicare costs is good news for Medicare financing and the federal budget.

Despite calls by some to keep MA payments “flat” by maintaining current funding levels, private insurers that choose to offer Medicare plans should not be insulated from market forces that are reducing the rate of growth of Medicare and health care costs. To do otherwise would give preferential treatment to private plans by continuing to overpay them – creating extra costs that must be subsidized by taxpayers and the majority of Medicare beneficiaries who choose *not* to enroll in MA plans.

ACA Does Not Put the Future of MA Program in Doubt

Reducing overpayments to MA plans does not threaten the security of the Medicare Advantage option. The MA program continues to be an option for beneficiaries who want it. In fact, MA enrollment is on the rise, increasing 30% from 2010 to 2013 to 15 million enrollees.¹³ According to Congressional Budget Office projections, enrollment in MA plans will continue to increase despite more payment parity with traditional Medicare, with an expected 21 million enrollees in 2023.¹⁴

IV. Recommendations for Further Improvement to the MA Program

To improve Medicare and Medicare Advantage for beneficiaries we recommend the following:

¹³ Jacobson, G., “Projecting Medicare Advantage Enrollment: Expect the Unexpected?” (Kaiser Family Foundation: July 2013), available at: <http://kff.org/medicare/perspective/projecting-medicare-advantage-enrollment-expect-the-unexpected/>.

¹⁴ Congressional Budget Office (CBO), “CBO’s May 2013 Medicare Baseline,” (May 2013), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205_Medicare_0.pdf.

- Provide better notice and consumer protections regarding MA plan benefits and network changes.
 - Require Medicare Advantage plans to provide notice at least 60 days before the Annual Enrollment Period when more than a certain percentage of their provider network is to be cut. And, regardless of the overall percentage, provide notice to each enrollee whose physicians or closest hospitals and nursing homes will no longer be in the network.
- Ensure network adequacy.
 - Review the definition of an adequate Medicare Advantage network to ensure all necessary services are available within a reasonable geographic area.
- Ensure clear, meaningful differences between plans offered by each Medicare Advantage Sponsor.
- Standardize benefits within plans – as exists for Medicare Supplement Insurance policies.
- Further limit out-of-pocket cost-sharing for enrollees in MA plans.
- Strengthen Traditional Medicare.
 - Level the reimbursement and coverage field in the two Medicare models. For example, include prescription drug coverage in traditional Medicare and ensure that other benefits available in MA are available in traditional Medicare.
- Improve Access to Medicare Supplement Insurance (Medigap).
 - Retain reasonably priced, first-dollar Medigap coverage.
 - As is the case in Connecticut and some other states, make it a federal requirement that Medigap insurance offer continuous open enrollment. Wider access to Medigap will give Medicare Advantage enrollees more flexibility to return to

traditional Medicare if their Advantage plan no longer meets their healthcare needs. Further, Medigap open enrollment rights should be extended to all Medicare beneficiaries, including those under age 65.

V. Conclusion

The Affordable Care Act has been characterized by some as gutting the Medicare program and hastening the death of the Medicare Advantage program. This could not be further from the truth. Many of the protests and concerns we hear now about ACA were lobbed at Medicare when it was enacted in 1965. Before long, most Americans came to see Medicare as a grand success, indeed a “sacred promise” to older and disabled people and their families. As a thirty year advocate for Medicare and Medicare beneficiaries, I can tell you that the Affordable Care Act is good for Medicare and those who rely on it for health coverage. As the Affordable Care Act is fully implemented, including the MA overpayment reductions, it will help ensure the continued stability of a full and fair Medicare program.

Instead of focusing on how much Medicare Advantage payments are being “cut,” Congress should focus on making sure MA plans provide what we’re paying for. It’s unfair to ask beneficiaries and taxpayers to shoulder extra payments to private Medicare plans. This is especially true since Medicare Advantage does not uniformly provide greater value. Enrollees in poor health often receive less coverage and all enrollees have fewer provider options than beneficiaries in traditional Medicare.

Thank you for the opportunity to testify regarding this important matter.

Respectfully submitted,

Judith A. Stein, Esq.
Executive Director

Mr. PITTS. The chair thanks the gentlelady and now recognizes Dr. Van de Water 5 minutes for an opening statement.

STATEMENT OF PAUL N. VAN DE WATER

Mr. VAN DE WATER. Mr. Chairman, Ranking Member Pallone, and members of the subcommittee, I appreciate the opportunity to be with you this morning. My statement reviews the role of private health plans in Medicare, identifies the factors that will hold down payments to Medicare Advantage plans in 2015, and explains why the Administration and Congress should reject demands from some quarters to freeze Medicare Advantage payment rates in 2015 at their 2014 levels.

For 40 years, Medicare beneficiaries have been able to receive their benefits through private health plans. And as you have heard, in 2014, 29% of beneficiaries are enrolled in a private health plan through Medicare Advantage and virtually all beneficiaries have access to such a private plan. The remaining 70% or so of Medicare beneficiaries are in traditional Medicare.

Congress' advisory body, the Medicare Payment Advisory Commission, has long recommended that Medicare's payment system be neutral, favoring neither Medicare Advantage plans nor traditional Medicare. But in recent years, the system has been substantially tilted in favor of private plans, the result of a large increase in MA payments enacted in the 2003 Medicare prescription drug law.

In 2009, Medicare paid MA plans 14% more per enrollee than what it would have cost traditional Medicare to cover comparable enrollees. The Affordable Care Act is gradually reducing MA payment rates to bring them more in line with payments in traditional Medicare. This year in 2014, Medicare Advantage payments average only 6% higher than the levels in traditional Medicare. These overpayments, I must add, drive up premiums for beneficiaries and weaken Medicare's finances.

The Centers for Medicare and Medicaid Services has recently announced preliminary 2015 payment policies for Medicare Advantage plans. Although the health insurance industry's trade association AHIP says that the CMS announcement includes "new proposed cuts," the agency CMS is simply applying current law.

The announced payment policies reflect four factors that will hold down MA payments in 2015. First, CMS continues to phase in the payment reductions that health reform requires, which curb some, but as I said, not all, of the excessive payments to MA plans.

Second, since MA payments are tied in part to the cost per enrollee in traditional Medicare, the continuous slowdown in fee-for-service spending lowers MA payment rates.

Third, CMS is implementing more accurate risk adjustment procedures as health reform requires. It will modestly reduce MA payments to address the problem of up-coding. Also, CMS will no longer include diagnoses identified during a home assessment visit rather than a clinical encounter in determining an enrollee's health status since these tend to make enrollees appear sicker than comparable enrollees in traditional Medicare.

And fourth, ending a demonstration project that pays higher-quality bonuses to some plans will effectively lower payments in those plans in 2015 compared to 2014.

Now, AHIP and other interest groups charge that the preliminary 2015 payment policies will substantially increase costs to MA participants and will reduce the choice of plans. They ask that MA payment rates be frozen in 2015 at their 2014 levels, but I would argue that the Administration and Congress should reject those demands.

The predictions of doom and gloom are greatly exaggerated. AHIP issued these same warnings about the MA payment cuts that were made in 2014, but MA enrollment, as you have noted, has nonetheless reached record levels. And the Congressional Budget Office projects that MA plans will continue to thrive despite further payment cuts. Nationwide, the number of plans available dropped by only 3% in 2014, a small change that reflects both the offsetting effects of newly entering plans and those departing the market.

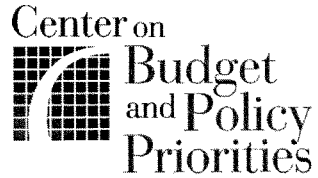
Plans also responded to the payment reductions by becoming more efficient. The unweighted average monthly premiums for MA plans with prescription drug coverage actually fell from 2013 to 2014 and is lower today than in 2011 or 2012. And again, this is also despite the payment reductions.

Wall Street certainly isn't pessimistic about Medicare Advantage. In the wake of the CMS announcement, shares of Humana, the second largest insurer in the MA market, recorded their biggest single-day increase in 4 years and reached their highest level in more than 30 years. Standard & Poor's overall index for managed healthcare plans also climbed.

Finally, preventing overpayments to Medicare Advantage plans is sound policy. Along with the other cost-saving provisions in the Affordable Care Act, eliminating overpayments reduces premiums for all beneficiaries, including the large majority who are not enrolled in MA plans and extends the solvency of Medicare's Hospital Insurance trust fund.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Van de Water follows:]



820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

March 13, 2014

Testimony of Paul N. Van de Water
Senior Fellow, Center on Budget and Policy Priorities
Before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Medicare Advantage

Mr. Chairman, Ranking Member Pallone, and members of the subcommittee, I appreciate the invitation to appear before you today. My statement reviews the role of private health plans in Medicare, identifies the factors that will hold down payments to Medicare Advantage (MA) plans in 2015, and explains why the Administration and Congress should reject demands to freeze MA payment rates in 2015 at their 2014 level.

The Role of Private Plans in Medicare

For 40 years, Medicare beneficiaries have been able to receive their benefits through private health plans, although the arrangements have evolved significantly over that time. In 2014, 29 percent of beneficiaries are enrolled in a private health plan through the Medicare Advantage program, and virtually all beneficiaries have access to a private plan.¹ The remaining 70 percent or so of Medicare beneficiaries are in traditional fee-for-service (FFS) Medicare, which allows them to receive care from virtually any licensed health care provider and to receive any covered service that they and their provider consider appropriate.

The Medicare Payment Advisory Commission (MedPAC) has long recommended that Medicare's payment system be neutral, favoring neither MA plans nor the traditional FFS system.² But in recent years, the system has been substantially tilted in favor of private plans — the result of a large increase in MA payments in the 2003 Medicare prescription drug law. In 2009 Medicare paid MA plans 14 percent more per enrollee than what it would have cost traditional Medicare to cover comparable enrollees. The Affordable Care Act (ACA) is gradually reducing MA payment rates to

¹ Secretary Kathleen Sibelius, Letter to the Honorable John Boehner, February 21, 2014; Scott Harrison, Kim Neuman, and Carlos Zarabozo, "Medicare Advantage program: Status update, and employer bid and hospice policies," Medicare Payment Advisory Commission, January 16, 2014.

² Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 287, http://www.medpac.gov/chapters/Mar13_Ch13.pdf

bring them more in line with payments in traditional Medicare, although some overpayments will continue in certain geographic areas. In 2014, MA payments average 6 percent higher than FFS levels.³ These overpayments drive up premiums for beneficiaries and weaken Medicare's finances.

Most elderly people are covered by the Hospital Insurance portion of Medicare (Part A) because they or their spouse have paid Medicare payroll taxes into the Medicare Hospital Insurance trust fund for at least ten years. Enrollment in Supplementary Medical Insurance (Part B, which pays for physician and other services) and outpatient prescription drug coverage (Part D) each requires payment of a monthly premium that covers about 25 percent of the cost of the insurance. General revenues cover the other three-quarters of the cost.

The Part B premium is a uniform national amount (in 2014, \$104.90 a month) that does not vary with a beneficiary's age or place of residence. Low-income beneficiaries are eligible for extra assistance to help pay their premiums and cost-sharing, and high-income people pay additional income-tested premiums. Under Part D, Medicare delivers prescription drug coverage exclusively through private insurance plans that contract with the program: either stand-alone drug plans or Medicare Advantage plans that package drug coverage with the rest of Medicare coverage. Almost 90 percent of Medicare beneficiaries also have some type of supplemental insurance that fills in part of Medicare's cost-sharing requirements and protects beneficiaries against catastrophic health care costs, which Medicare (unlike most employer-sponsored health plans) does not fully cover.

Beneficiaries enrolled in an MA plan must pay the Part B premium (less any rebate that the private plan provides), and they often pay an additional premium specific to the MA plan for prescription drug coverage and supplemental benefits. Medicare payments to MA plans are generally tied to local per capita expenditures in traditional fee-for-service Medicare and to the plans' "bids" (their estimated cost of providing Part A and B benefits to an average enrollee). Medicare also adjusts its payments to MA plans to reflect the health status of each plan's enrollees.⁴

Federal law requires Medicare Advantage plans to offer the same basic benefits as traditional Medicare and prohibits them from charging higher cost sharing. To the extent that MA plans have been overpaid or can deliver care more efficiently, they can offer benefits beyond those that traditional Medicare provides. The most common enhancements are reductions in cost sharing and additional services such as dental and eye care and wellness benefits. Since 2011, all MA plans must limit in-network out-of-pocket costs (excluding premiums) to \$6,700 a year; traditional Medicare has no limit on out-of-pocket costs.

Preliminary 2015 Payment Policies for Medicare Advantage

The Centers for Medicare & Medicaid Services (CMS) recently announced preliminary 2015 payment policies for Medicare Advantage plans.⁵ Although the health insurance industry's trade association, America's Health Insurance Plans (AHIP), says that the CMS announcement includes

³ Harrison and others, "Medicare Advantage program."

⁴ For an explanation of how MA plans are paid, see MedPAC, *Medicare Advantage Program Payment System: Payment Basics*, October 2013, http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_MA.pdf.

⁵ Centers for Medicare & Medicaid Services, "Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter," February 21, 2014, <http://cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2015.pdf>.

“new proposed cuts,” the agency is simply applying current law.⁶ The announced payment policies reflect four factors that will hold down MA payments in 2015.⁷

- **Curbing excessive payments.** CMS continues to phase in the payment reductions that health reform requires, which curb some (but not all) of the excessive payments to MA plans. Depending on the county in which an MA plan operates, some of these reductions have already been fully implemented, some will be fully implemented in 2015, and some won’t be in full effect until 2017.
- **Slowdown in cost growth.** Under the Affordable Care Act, payments to MA plans are tied in part to the cost per beneficiary in traditional fee-for-service Medicare. With Medicare per-beneficiary spending continuing to grow at historically low rates, CMS has again revised downward its cost assumptions, which lowers MA payment rates.
- **More accurate risk adjustment.** As health reform requires, CMS will modestly reduce MA payments to address the problem of “upcoding,” under which the diagnosis codes that plans assign to their enrollees to report their health status make the enrollees appear to be sicker than they actually are — which, in turn, causes Medicare to overpay the plans. Also, CMS will no longer include diagnoses identified during a home assessment visit (rather than in a clinical encounter) in determining an enrollee’s health status, since they also tend to make enrollees appear sicker than comparable enrollees in traditional Medicare.
- **Ending a demonstration project.** CMS awards quality and performance ratings to MA plans — with ratings from one star (worst) to five stars (best) — based on enrollee satisfaction, access to care, and other measures. A demonstration project that runs from 2012 through 2014 allows plans with a three-star quality rating to receive bonus payments otherwise available only to four- or five-star plans and allows five-star plans to receive enhanced bonuses. CMS is ending the demonstration project on schedule, which effectively lowers payments to three- and five-star plans in 2015, relative to 2014.

Assessing Medicare Advantage Payments

AHIP and other interest groups charge that the preliminary 2015 payment rates will substantially increase costs to MA participants and will reduce the choice of plans. They ask that MA payment rates be frozen in 2015 at their 2014 level. The Administration and Congress should reject these demands.

The predictions of doom and gloom are greatly exaggerated. AHIP issued the same warnings about the MA payment cuts made in 2014, but MA enrollment has nonetheless reached record levels. The Congressional Budget Office projects that MA plans will continue to thrive, despite further payment cuts.⁸ Nationwide, the number of plans available dropped by only 3 percent in

⁶ America’s Health Insurance Plans, “Statement on New Proposed Cuts to Medicare Advantage,” February 21, 2014, <http://www.ahipcoverage.com/2014/02/21/ahip-statement-on-new-proposed-cuts-to-medicare-advantage/>.

⁷ Edwin Park, “As Expected, No New Medicare Advantage Cuts,” *Off the Charts* blog, February 24, 2014, <http://www.offthechartsblog.org/as-expected-no-new-medicare-advantage-cuts/>.

⁸ Edwin Park, “Health Reform Won’t Cripple Medicare Advantage, Latest CBO Estimates Show,” *Off the Charts* blog, May 23, 2013, <http://www.offthechartsblog.org/health-reform-wont-cripple-medicare-advantage-latest-cbo-estimates-show/>.

2014, a small change that reflects the offsetting effects of newly entering and departing plans. Plans also responded to the payment reductions by becoming more efficient. The unweighted average monthly premium for MA plans with prescription drug coverage fell from 2013 to 2014 and is lower today than in 2011 or 2012.⁹

Wall Street certainly isn't pessimistic about Medicare Advantage. In the wake of the CMS announcement, shares of Humana, the second largest insurer in the MA market, recorded their biggest single-day gain in four years and reached their highest value in more than 33 years. Standard & Poor's composite Managed Health Care Index also climbed.¹⁰

Moreover, preventing overpayments to Medicare Advantage plans is sound policy. Along with the other cost-saving provisions in the Affordable Care Act, eliminating overpayments reduces premiums for all beneficiaries, including the large majority who are not enrolled in MA plans, and extends the solvency of Medicare's Hospital Insurance trust fund. If Medicare's benefits are to be improved, equity requires that they be improved for all beneficiaries — not just the minority who are enrolled in MA plans. That's the approach taken in the ACA, which has added coverage of preventive health services without cost sharing and is gradually closing Medicare's prescription drug "donut hole."

Because both Medicare Advantage plans and traditional Medicare have their own unique strengths, they should compete on a level playing field. Traditional Medicare, in particular, has been the leader in instituting reforms in the health care payment system to improve efficiency and constrain costs. Because of its large buying power, traditional Medicare can implement payment and delivery system reforms that private insurance companies cannot. To assure that traditional Medicare can continue to play this crucial role, Medicare's payment and other policies should not be tilted in favor of Medicare Advantage plans.

⁹ Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, *Medicare Advantage 2014 Spotlight: Plan Availability and Premiums*, Kaiser Family Foundation, December 2013, <http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8520-medicare-advantage-2014-spotlight2.pdf>.

¹⁰ Caroline Chen, "Humana Leads Insurer Gains on Proposed Medicare Payments," *Bloomberg*, February 24, 2014, <http://www.bloomberg.com/news/2014-02-24/humana-leads-insurer-gains-on-proposed-medicare-payments.html>.

Mr. PITTS. The chair thanks the gentleman. That concludes the opening statements. We will begin questioning. I will recognize myself for 5 minutes for that purpose.

Mr. Little, I will go first to you. What would have happened to you if you had had a health episode and were not on an MA plan? How did your MA plan compare to what service you might have received under traditional Medicare if you could explain?

Mr. LITTLE. If I would have had traditional Medicare with my problems that I had, instead of being approximately \$400 out-of-pocket cost because I stayed 2 extra days at the hospital when I had the open heart, if I had had traditional Medicare, it would have cost me \$150,000 and that is a financial burden.

Mr. PITTS. Now, what would happen to you if you would lose your MA plan that you have today?

Mr. LITTLE. Well, if I had looked at the closest Medigap and it would add about \$700 to \$800 a year to my cost, which, because I am retired, something would have to be taken out of the budget to pay for the plan.

Mr. PITTS. All right. Well, according to the Congressional Budget Office, the Affordable Care Act cut more than \$300 million from the Medicare Advantage program to spend on new government programs, new entitlement not for seniors. What is your reaction to that?

Mr. LITTLE. Well, I have seen the cuts. When I turned 65 5 years ago, we had four plans to choose from and Medicare Advantage plans and I had always been with Blue Cross Blue Shield so I signed up with them. I was informed the following year that they were dropping that plan so I went to Optima. They had the next-best plan. The following May I got my letter that they were dropping me, and the third year I went to Humana because they were basically the only one left. And in my area that I live in, Virginia Beach, Humana offers the only Medicare Advantage plan available. The others said they had to drop it because of the higher cost and cuts.

Mr. PITTS. Can you describe what your plan has done for you that you think may have prevented a hospitalization or from returning to the hospital?

Mr. LITTLE. Yes, sir. Every January and June part of the plan is to go into your GP and have a thorough checkup. And of course I have to go to my cardiologist and have a thorough checkup. But even the co-pay for those preventive is zero for a GP and of course my specialist is \$35, which is easily affordable. So they keep me running.

Mr. PITTS. If you could do a ballpark, how much do you think your health plan has saved you in costs out-of-pocket, you know, costs for the services you need so far?

Mr. LITTLE. Well, I know in the last 5 years it has saved me \$140, \$150,000.

Mr. PITTS. Now, due to cuts in Medicare Advantage under the Affordable Care Act, some seniors may get to keep their plan at least this year but might still lose their doctor or lose affordable premiums or lose needed benefits. Have you lost your doctor or plan before?

Mr. LITTLE. No, sir.

Mr. PITTS. Have you or your friends with Medicare Advantage plans experienced fewer choices and higher cost?

Mr. LITTLE. We have experienced fewer choices but the low cost is still there. And in fact, with all respect to Ms. Stein, I don't know which Medicare Advantage plan they have, but they need to switch.

Mr. PITTS. All right. Let me go to Mr. Giese. What are the tools that CMS has at its disposal to legally reduce the impact of the cuts and the advance notice through administrative or regulatory means?

Mr. GIESE. Some of the cuts are statutory and some of the cuts are discretionary, so if Congress were to act, things like the ACA reductions, the demonstration plan, and the risk score stuff could be changed. But the other stuff that is discretionary is decided by CMS, so the rate book change, which are the trends in Medicare Advantage, we are not quite sure how CMS develops the trends. They are not really released to the public. So that could change. That is partially discretionary and I would say that is the biggest one.

Mr. PITTS. My time has expired, unfortunately. The chair recognizes the ranking member 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask questions initially of Mr. Van de Water. I have heard different views on whether the quality of care that Medicare beneficiaries receive from an MA plan is any different than fee-for-service Medicare. What is your take on the relative quality of care provided in fee-for-service versus MA plans?

Mr. VAN DE WATER. Mr. Pallone, I think the short answer is that we don't really have clear data. I like to rely on the Medicare Payment Advisory Commission. They are a good impartial source. And in their report from last March on Medicare payment policies, they said that according to them we have little information on which to base a comparison of MA quality indicators with those in private fee-for-service.

That having been said, the evidence is mixed. There are some studies which some of the Members have referred to that suggest that at least in some particular MA plans, quality may be better. There is other data, for example, that MedPAC sites that suggests that the quality is about the same on average in Medicare Advantage plans and traditional Medicare. So I think the right answer is that the record is probably mixed that in some cases the quality is probably better but we can't make that conclusion across the board.

Mr. PALLONE. Well, I think we should strive to improve the quality provided to all Medicare beneficiaries both in the fee-for-service system and the Medicare Advantage program. Now, fee-for-service has undertaken new payment models such as accountable care organizations, medical homes, and other initiatives, and Congress, including our committee, has made great bipartisan progress towards tying physician Medicare payments more closely to the quality of care provided. And now that MA plan payments are linked to quality performance, the plans are also working to improve quality. So what is your recommendation for steps we can take to continue to improve quality for all Medicare beneficiaries?

Mr. VAN DE WATER. Well, I think you are exactly right to focus on the whole system. You know, we are developing—this is referred to a mix of payment models. We have not only traditional Medicare on the one hand and Medicare Advantage plans, but we are developing intermediate models such as accountable care organizations. I think that what Congress has done to encourage these different payment models is exactly the right thing. In your proposed SGR legislation you have additional steps to develop models of that sort. The quality bonuses in MA plans, that makes sense. So I think in general you are on the right track.

Mr. PALLONE. All right. Let me ask you a question about the mechanics of how Medicare Advantage plans are paid. CMS reported that the proposed reductions will result in a 2.4 decrease to MA plan benchmarks in 2015 while the witness from Oliver Wyman testified on their recent report and that is a report that I remind everyone that the insurance industry paid for, which claims that the plans' rates will be cut by 5.9%. And the plans are saying these reductions are going to either put them out of business, force them to hike premiums, reduce benefits, or take other drastic measures. On the other hand, they said this last year, too, and yet nothing really happened. But I know this is a very complex issue and I would like to get to the bottom of it.

So let's just talk about the facts. Can you please explain the mechanics of how Medicare Advantage plans are paid, like what a benchmark is, what a bid is, and how plans' payments are determined?

Mr. VAN DE WATER. I will try to give a simple answer which will necessarily be a bit oversimplified, but, as you say, the key factors in determining what a plan gets paid are, one, the plan's bid, which represents how much the plan estimates that it will cost to provide Part A and Part B services to a representative group of people, that is people of sort of an average—

Mr. PALLONE. What I am trying to get at is whether the reductions that CMS has proposed to the plan, you know, whether the reductions are to the payments or the benchmarks? And given the reductions in benchmarks, will the plans on average end up getting less money than fee-for-service? But, you know, go ahead.

Mr. VAN DE WATER. OK. The answer is that the reductions that are being discussed are the reduction to the so-called benchmarks. What the plans actually get relates both to the benchmarks and to what they bid and to other factors, so there is a lot of intervening steps, and reductions in the benchmarks don't translate one-for-one into reductions in the plan payments.

Mr. PALLONE. So can we say that the proposed reductions and benchmarks will on the average end up that the plans get less money than fee-for-service Medicare?

Mr. VAN DE WATER. Other things being equal, they will tend to reduce what the Medicare Advantage plans get paid, but on average, in 2015 MA plans are still going to get paid, somewhat more than what it would cost to cover their enrollees under traditional Medicare.

Mr. PALLONE. All right. Thank you.

Mr. PITTS. The chair thanks the gentleman and now recognizes the vice chairman of the subcommittee, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman. I would like to address this to Dr. Lew and Mr. Giese. I mean you heard the ranking member's question to Dr. Van de Water about the issue of quality between Medicare Advantage and traditional Medicare. Can you offer us your perspectives on that? Is there a difference in your estimation on the difference between the quality of care provided the enrollee in traditional Medicare versus Medicare Advantage? Dr. Lew, let's start with you.

Dr. LEW. Yes. Thank you for that question. Absolutely I can attest to that, that the quality of care delivered in a coordinated care model is far superior to a fragmented fee-for-service system because you have got the whole continuum of care. Again, as I mentioned, the home visits coordinated with inpatient, outpatient visits, palliative care and disease management. It is a team approach where you have got providers, nurses, pharmacists, social workers taking care of patients across the continuum.

There was a mention about home care. Home care absolutely is an essential piece of this. You take out home care; that leaves a gap in our system. You know, it is not an up-coding situation. It is a situation where we do actually recognize what could be admission drivers. We look for areas where a patient, perhaps he would be at a fall risk. So there is a lot of information gathered at a home visit. But absolutely, quality measures, there is no question. We can reduce bed days, we reduce lengths of stay, we reduce costs, we get better outcomes and obviously patient satisfaction, and that is why members are wanting to migrate to Medicare Advantage.

Mr. BURGESS. Thank you.

Mr. Giese?

Mr. GIESE. Thank you. There are studies out there that show that the quality in fee-for-service is lower than in MA on average, in fact, a number of studies. But going beyond that, think about your parents and if they are sick. They want to be taken care of. These people who sign up for Medicare Advantage plans are so happy that they are taken care of. They are called by the plan to say, did you take your prescription? Did you get a checkup? And the people love this. It is so important to these people who signed up for these plans.

Mr. BURGESS. Have there been any efforts to identify—you know, we talk on this committee a lot about readmission rates for patients with certain diagnoses. Is there any evidence to point to, say, the readmission rate for someone who is hospitalized with congestive heart failure that is partly controlled, that is hospitalized, gets toned up, gets sent home? Do they do better or worse on Medicare Advantage?

Mr. GIESE. Readmission rates are lower in Medicare Advantage. There have been some studies that show that.

Mr. BURGESS. Well, let me ask you a question and then because part of this is we overpay Medicare Advantage. But you have just identified one of the larger cost drivers and you say that is less with Medicare Advantage. So how can it be? A program that costs more is actually costing less? It is paradoxical, isn't it?

Mr. GIESE. Well, all of the——

Mr. BURGESS. It is a trick question, Mr. Giese. I am sorry. I couldn't help myself. Dealing with the Congressional Budget Office all the time——

Mr. GIESE. All of the so-called overpayments to Medicare go directly to beneficiaries. The rules for bids and the way the bids work, everything goes back to the beneficiary.

Mr. BURGESS. And I thank you for that. I did just want to point out we deal with the tyranny of the Congressional Budget Office all the time and it is bipartisan. Both sides of the dais feel the tyranny of the Congressional Budget Office.

Mr. Little, I just have to ask you a question.

Mr. LITTLE. Yes, sir.

Mr. BURGESS. Your written testimony you have provided you said you were a small business owner?

Mr. LITTLE. Yes, sir.

Mr. BURGESS. So were you self-employed?

Mr. LITTLE. Yes, sir.

Mr. BURGESS. So being self-employed, you know of course you paid your taxes, your payroll taxes?

Mr. LITTLE. Yes, sir.

Mr. BURGESS. And for Medicare Part A, what was the payroll tax that you paid during most of your years?

Mr. LITTLE. Well, nobody in my organization was that old at that time.

Mr. BURGESS. Well, but I mean as you worked, in your working years you pay Social Security and Medicare——

Mr. LITTLE. Oh, yes.

Mr. BURGESS [continuing]. Every paycheck, right?

Mr. LITTLE. Oh, yes, sir.

Mr. BURGESS. Do you remember what the percentage was that you paid for Medicare?

Mr. LITTLE. The FICA was 6.2. The Medicare was—I don't know.

Mr. BURGESS. 1.3, I have it on good authority. It is said it is 1.3 so let's stipulate that that is correct. But you were a small business owner so for yourself you paid both the employer and the employee contribution, is that correct?

Mr. LITTLE. Yes, sir.

Mr. BURGESS. So you paid 2.6% of your earnings throughout your lifetime. So let me just ask you. Do you feel that what you are receiving now and Medicare is an entitlement or is that something for which you have paid?

Mr. LITTLE. Oh, I think it is something I have earned.

Mr. BURGESS. Yes, exactly. Exactly so. And I just wanted to make that point. It is then incumbent upon us to make sure you get the very best of what is available, and in your case, it sounds like that would be Medicare Advantage.

I have gone over time. I will yield back.

Mr. PITTS. All right. The chair thanks the gentleman. I now recognize the gentleman, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

CMS proposed to disallow the use of the home assessment diagnoses unless the beneficiary received appropriate follow-up care as a good policy. Mr. Van de Water, I understand that plans were al-

lowed to use beneficiary diagnosis information obtained during home assessment visits to increase their risk adjustment payment. Basically what happened is that the plans were providing assessments for beneficiaries finding that there were certain diagnoses and using that information for increased payment.

But this is important in that plans were not following up and providing the services the patient required as a result of that diagnosis. So the plans get more money and the patient doesn't receive anything. This seems like it is a scam on tax dollars. Just so we are clear, can you please explain exactly what CMS has proposed?

Mr. VAN DE WATER. Yes, sir. I think you actually provided a very good summary yourself. All I would add is that what CMS is proposing to do is not an anyway suggesting that these home assessment visits cannot be helpful or useful, but as you say, it is important that if a home assessment visit takes place and a condition is found, that the appropriate follow-up is provided. CMS is not saying that diagnoses identified during home visits are never going to be considered but simply they do have to be recognized by the subsequent encounter with a doctor or health professional to make sure that the appropriate follow-up is indeed taking place.

Mr. GREEN. It seems like if they are getting paid for that assessment of that illness, they should be actually treating that patient—

Mr. VAN DE WATER. Exactly.

Mr. GREEN [continuing]. Instead of just building up their payment.

What is your take on this policy? Is it reasonable to require a plan if they wish to receive higher payments with identifying a diagnosis to require they provide that patient with those services?

Mr. VAN DE WATER. I am not sure we need to make the requirement but we certainly shouldn't allow plans to get the higher payments for the diagnoses if they are not followed up on.

Mr. GREEN. In other words, that is a cost savings we could do. But we hear about in Medicare is overpayment if they are not receiving the services that they are actually being paid for.

Mr. VAN DE WATER. Yes. That is precisely what CMS has tried to do in the proposed policy.

Mr. GREEN. Medicare Advantage overpayment often hurt beneficiaries and Medicare in the long run. Ms. Stein, I know that you have been a strong advocate for strengthening Medicare and ensuring it remains secure in the long run. That is why I have concerns about continuing to overpay Medicare Advantage. First, Medicare Part B premiums are based on program spending, so the extent Medicare is paying too much, it drives the beneficiary premiums up, isn't that right?

Ms. STEIN. That is exactly correct. The overpayments to the Medicare Advantage program are a problem not only for Medicare Advantage enrollees but for all Medicare beneficiaries because their Part B premiums increase and of course taxpayers pay more for Medicare as a whole.

Mr. GREEN. We know that most beneficiaries have modest incomes, fixed incomes. They don't have a lot of disposable income to pay extra to manage care. How are beneficiaries affected by unjustified overpayments to private insurance companies while the

minority who are enrolled in plans might see some additional benefits but how the vast majority of Medicare beneficiaries are affected? It seems like if you are raising premiums for—and I will take a number out of the air—70% of the folks in my district, last numbers I saw, received regular Medicare, about 30% do Medicare Advantage. So you raise the premiums for 70% to provide some additional benefit to the 30%.

Ms. STEIN. That is correct. And I have to even question the additional benefits. I mean what were mentioned were vision, which is usually some help with some eyeglasses, not very much, and preventive services, which are now zero based in Medicare as a result of the Affordable Care Act. And I have not seen a great deal of actual coordination. When there is true coordination, I applaud it, but very often, we have as much siloing of care in Medicare Advantage as we have in traditional Medicare. It is costing everybody more, even the vast majority who don't choose Medicare Advantage but stay in traditional Medicare.

Mr. GREEN. Well, I only have a few seconds left and I have heard some folks argue that we can't take away access payments to plans and put them on parity with fee-for-service because some beneficiaries are low-income, rely on these plans for additional benefits. And they do. I know Medicare Advantage offers other things, but the problem is plans can change their benefits and cost-sharing from year to year. Just because a low-income person has a plan that would reduce cost-sharing today, that plan doesn't necessarily have to offer that extra benefit over that year.

Ms. STEIN. That is right. The plans can change the benefits from year to year so long as they are actuarially equivalent to traditional Medicare.

And I just want to say CMS did do a study in 2012 that showed about low-income people, people with high-risk needs and health issues disproportionately disenroll from Medicare as they are dealing with those issues across the country.

I have no skin in this game. My entire career is just representing mostly low- and moderate-income Medicare beneficiaries and protecting Medicare. That is all I care about here and getting access to care. And I think the Medicare Advantage plan is providing way too much money for way too little uniform value and it is hurting the Medicare program and most Medicare beneficiaries. I say that as an advocate, as a cancer survivor, and as the daughter of a woman who is just going through an extraordinary neurosurgery that was available to her because she was in traditional Medicare.

I can't understand why it would cost Mr. Little \$100,000 and I hope he will call my office if we can ever help him. We don't charge for our services.

Mr. GREEN. OK. Thank you, Mr. Chairman. I know I am over my time but I thank all of our witnesses for being here.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman, and thank you to our panel for being here today.

I just want to start off by associating myself with some of the comments, Dr. Lew, you said our seniors enjoy their Medicare Ad-

vantage plans, and it is so important that we work in Congress to protect them from these large cuts that will negatively affect 476,000 North Carolina seniors that I have the incredible honor to represent.

I am very concerned about this issue because I do believe it is a choice that our seniors are able to make. I think that our seniors are in jeopardy when they cannot make choices for themselves. Mr. Little has made a choice of what it is that he would like to see for his coverage, and I don't understand why we would consider jeopardizing that ability. When something works for someone, they should keep it. Isn't that what our President said? If you like your healthcare plan, you should be able to keep it. Yet, now we are saying no, as a matter of fact, you can't.

And, Dr. Lew, thank you for your comments about patients in the home-health setting. You know, our seniors want to take care of themselves. Our seniors want to be able to be independent, and if they are going to do a better job recovering from surgery or sickness, illness at home, I think that is where they need to be. I think these are all the things that are jeopardizing our system.

And to the point that Dr. Burgess was making earlier about savings in one part of Medicare only to spend more money in another, if we are helping to keep seniors out of the hospital or the inpatient setting, that is a dramatic savings within Medicare. So it only makes sense to me that we would continue to advocate another program, or Medicare Advantage would help seniors be able to do that. You know, keeping people out of the hospital is the best way we can keep people healthy and safe in this country.

Dr. Lew, as a physician, do you believe seniors in rural areas—I have a large rural area in my district. How do you feel about seniors in the rural setting? How do you feel that they respond to the higher premiums or potentially no Medicare Advantage offered? I mean, how will that affect them?

Dr. LEW. Well, if Medicare Advantage plans pull out of certain markets, that will certainly leave seniors very vulnerable. You know, there are some parts of certain States that we do business in where there are very few Medicare Advantage plans. In fact, recently, one plan pulled out of one of these States where we do business and that left one dominant player, which is very vulnerable, because after that one player pulls out, the seniors are going to be left without physicians and without a network. But hopefully that won't happen.

And, to your point about seniors liking choice and having choice, and having the better outcomes on the back end, that is all a result of what we have built, this coordinated-care model and what I consider an investment, not an overpayment, but an investment into this model that we have shown has worked that we are threatening now to jeopardize by cuts. That is what I am concerned about because that is going to impact the physicians and the seniors.

Mrs. ELLMERS. Absolutely. And, there again, to me it is a matter of common sense. I struggled with the idea that the Obama Administration and that CMS would choose to hit something that is working so well as Medicare Advantage when we have numerous programs that don't work at the federal level. As a fiscally responsible

individual representing my constituents, this is simply not the place that we should go for savings. There are many others.

And again, Mr. Little, I just want to thank you on behalf of my constituents, my seniors for coming forward and sharing your stories and your experience with the healthcare issues that you had to deal with, with heart disease and cancer, because that is just so important. Your recovery and your ability to recover on your own terms probably had a lot to do with the Medicare Advantage plan that you chose.

Mr. LITTLE. Yes, it did. And one thing I would like to interject that I didn't before, I have noticed it because I have been with the Medicare Advantage plan for 5 years. The costs are kept down mainly because of what they pay the hospitals, the physicians.

Mrs. ELLMERS. Yes.

Mr. LITTLE. I have noticed my checkup this year was \$300. My doctor—

Mrs. ELLMERS. Yes.

Mr. LITTLE [continuing]. Got \$74. There it is.

Mrs. ELLMERS. Yes.

Mr. LITTLE. There is your savings. It is not costing the government any extra money. They are negotiating, but of course that is why—

Mrs. ELLMERS. That is right.

Mr. LITTLE [continuing]. Several of the Medicare Advantage plans dropped out because they couldn't get down—

Mrs. ELLMERS. Yes.

Mr. LITTLE [continuing]. To that price.

Mrs. ELLMERS. Yes.

Mr. LITTLE. And also with every claim that I do, and they send me what I did, they also send a letter if you see any fraud or anything that was done that wasn't really done, please let us know immediately. So they self-govern themselves and I think that is how they are keeping the cost down.

Mrs. ELLMERS. Well, thank you again for being such a great advocate on this issue. We truly appreciate it and my constituents thank you.

Mr. LITTLE. You are welcome.

Mrs. ELLMERS. Mr. Chairman, I would like to submit to the record a letter that we sent to Ms. Tavenner from the Doctors Caucus. Members of the Doctors Caucus put it together; I would like to submit it for the record.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mrs. ELLMERS. Thank you, sir, and I yield back the remainder of my time.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentlelady from Virgin Islands, Dr. Christensen, 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Ms. Stein, we have heard a lot today about Medicare Advantage plan choices and how seniors need to have a lot of choices of different plans, but like you, I believe that the most important choice that a senior can have is a choice of a doctor, the ability to access

your physician or even a hospital where you are familiar with the services and you know you will get good care.

You spoke about Connecticut where you are headquartered and where there was a serious problem when Medicare Advantage plans abruptly dropped providers from the network leaving beneficiaries, who had selected a plan based on being able to continue to see their doctors, in the lurch. To me, this highlights a very serious problem with Medicare Advantage. Plans make these choices to contract with a provider and that is a result of really business decisions. This is part of the downside of having private insurance companies whose main goal it is to make a profit serving vulnerable seniors. What recommendations might you have for how Congress and CMS could better protect seniors that Medicare Advantage plans from such disruption?

Ms. STEIN. Thank you. I appreciate this opportunity.

I think that the choice that people want of whatever age is the choice of who is going to take care of them and where they are going to be taken care of. And traditional Medicare is pretty much an open network. You can go around the country. So, for example, my mother has just come from western Connecticut to eastern Connecticut to be in a nursing home near me. If she was in a Medicare Advantage plan in our State, that wouldn't be possible.

So you can go near family, you can choose pretty much all the doctors that are providing care, not all but most, and also, as I said, Yale New Haven Hospital is no longer in the largest Medicare Advantage plan in our State and that is certainly not because of quality of care and that is because before these further level playing field of Medicare Advantage to the costs of traditional Medicare.

One of the things I think is that we should relook at the definition of an adequate network in Medicare Advantage plans and make sure that the definition is truly going to meet the needs of the people who enroll. We should look to providing enrollees whose plans terminate contracts with their doctors, that they must be given notice regardless of what the plan thinks of the adequacy of the network after that doctor and their hospital is terminated. If the physician or local hospitals that this person is known to use have been terminated from that plan, they should be given notice of that before it is effective.

We should ensure clear, meaningful differences between the different Medicare Advantage plans that a given sponsor is offering because it is very hard for people to know what they are choosing very often. We should standardize benefits within plans, as Congress intelligently did with Medicare supplement, Medigap, plans many years ago. You can really tell apples to apples and know what you are getting.

I would say finally, perhaps most importantly, we should make sure that there is a true even, level playing field in benefits and payments to traditional Medicare and Medicare Advantage. If we want people to truly have choice, besides of their doctors, between Medicare Advantage and traditional Medicare, we should make sure that the benefits are available in both. Now, because of the Affordable Care Act, we have mostly zero cost preventive services in traditional Medicare. We should have the same reimbursement

structure for those who provide care in traditional Medicare as in Medicare Advantage.

We should offer prescription drug coverage in traditional Medicare because people often go to Medicare Advantage now because it is the only one-stop shopping. It is the place where it is simpler. You go there, you get your prescriptions usually and your other services. So they feel they don't have that choice.

Also, it is called Medicare Advantage. People think they have some advantage. They think they are getting something on top of Medicare. There should be a level playing field between the two operating choices, the two models.

Mrs. CHRISTENSEN. Well, thank you. And I think some of those, especially the adequate network, could be applicable. There is a very troubling situation happening in Tennessee, Florida, and Texas in dental Medicaid managed care where providers are being dropped, and I hope that maybe at some point we can have a hearing on Medicaid managed care as well.

Thank you for your time.

Ms. STEIN. It has been a huge issue in our State and we lost almost all our Medicare Plus Choice plans. And now, before these reductions and overpayments are in effect, United Healthcare dropped 2,250 physicians and hospitals and other care providers in Connecticut. That was a provider for 1 for every 200 Medicare beneficiaries in our State. It has been stunning. And I fear this is going to be used as an argument for even higher payments to Medicare Advantage when, if we could put that money into traditional Medicare, all 50 million Medicare beneficiaries would benefit and taxpayers would pay less.

Mr. PITTS. The chair thanks the gentlelady, recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. LANCE. Thank you very much, Mr. Chairman.

I recently had a constituent contact me to inform me that her Medicare Advantage plan had been canceled and her new plan requires her to pay \$600 per month, which is \$50 more than her previous plan, with no indication that she will maintain her current plan benefits or the doctor she likes. It is my experience that this woman, my constituent, is not alone. According to Oliver Wyman actuaries, New Jersey, the State I represent, will be one of the States hardest hit by these proposed cuts. Approximately 217,000 New Jerseyans are enrolled in Medicare Advantage and they may see a reduction in benefits.

And, Mr. Little, thank you for being here with us today, and I am hoping you can tell us a little more about your experience with Medicare Advantage and I imagine it is similar to the experience of those in the district I serve who have reached out to me. Would you please explain, sir, to the committee why you chose a Medicare Advantage plan over traditional Medicare?

Mr. LITTLE. Well, I go to the gym.

Mr. LANCE. Yes. My wife tells me I should go more often.

Mr. LITTLE. Well, you will find it is really a convention of old people talking. We shoot the bull more than we exercise to be exact. But when I first became of age, 65—

Mr. LANCE. Yes, sir.

Mr. LITTLE [continuing]. All the men that were in the gym and stuff say, well, make sure you look at the advantage plan; that is what you want to go with.

Mr. LANCE. Yes, sir.

Mr. LITTLE. And so I Googled it and, of course, came up with four plans that were available. All of them were great. I took Blue Cross Blue Shield because I had been with them all my life when I was in business in a regular plan. Of course, they dropped it the following year due to financial things. Then, I shifted to Optima and then they dropped it the following year. So then I only had Humana left. That is the only one left in my place. And they had been great. Whatever my GP says, when he found the mitral valve going bad in my heart, he immediately sent me next door to the cardiologist, and at 6:00 a.m. the next morning they had my heart laying on the table fixing it. And of course Norfolk Heart is one of the top 10 in the Nation.

There is never, ever in the last 5 years, between my pulmonary and my other physicians, anything about not being able to have the best service there is and the one of my choice. And of course for the last 12 years since I retired I have kept my same doctor.

Mr. LANCE. When you had your open-heart surgery, your primary care doctor worked with your specialist to ensure that you received the care you needed. Is that your testimony?

Mr. LITTLE. Yes, sir. He called right then. He said you need to go right now because he heard something. And I went to the cardiologist, which happened to have his office next door, and he picked up the phone and he said be at Sentara Heart tomorrow morning at 6:00 a.m. So it was fairly quick.

Mr. LANCE. Thank you. Under traditional Medicare without a supplemental policy I think that some senior citizens could face financial difficulty and perhaps even worse than financial difficulty due to the unpredictable cost-sharing from unexpected illnesses or hospitalization, and that is certainly one of my concerns.

Dr. Lew, in your testimony you described how Medicare Advantage incentivizes value and coordinating care whereas that is not always the case with the fee-for-service Medicare program. Would you please elaborate on the importance of coordinated care and what this means for our Nation's senior citizens?

Dr. LEW. Right. Coordinated care, essentially, is it is a team—

Mr. LANCE. Yes.

Dr. LEW [continuing]. Not just physicians, the whole, you know, team of pharmacists and social workers and case managers working along a continuum of care. So it is not just when a patient comes into a hospital. It is home, hospital, office. It is throughout no matter what type of problem that they have.

You know, and the other thing I wanted to note is we are not a health plan. We are a physician group.

Mr. LANCE. Yes, sir.

Dr. LEW. And so we get 85 cents on the dollar that is passed to us. So what might look like a level playing field is not when it gets down to the physician level, and that is what we are dealing with when we are trying to deliver these extra services and provide the great care to the seniors.

Mr. LANCE. Thank you. I think the testimony has been compelling and certainly I hope that Medicare Advantage can continue. That is a certainly my perspective based on my representation of New Jersey.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. OK. I guess Mr. Guthrie is here. The chair recognizes Mr. Guthrie 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman. Let me move over to the microphone so it will be picked up. Thank you, Mr. Chairman. I have a question for Dr. Lew.

Some people have suggested that insurance companies are being overpaid for Medicare Advantage and rates should be cut to fee-for-service levels for equity. What do you think the impact would be for patients if it was cut to fee-for-service levels?

Dr. LEW. Well, I think that the investment that was made has been made over the years to build this model, which I think now we are seeing the results of and the seniors like it and that is why they are migrating over. I think that was a smart investment.

Now that we are facing cuts, which are really starting to roll in right now—just January of this year I see it happening with our company—you know, it is going to impact physician payments. It will impact programs and services that we are able to provide to seniors. And as these cuts continue throughout '14 and '15, I think that is just going to get worse.

Mr. GUTHRIE. And how long have you cared for seniors with Medicare Advantage plans and what do you think they like the most about being in Medicare—

Dr. LEW. I am sorry. I didn't hear that first question.

Mr. GUTHRIE. How long have you cared for seniors in Medicare Advantage plans and what do you think they like the most about being in Medicare Advantage?

Dr. LEW. Our company has been taken care of Medicare Advantage patients for 20 years and, you know, what I think the seniors like is, again, the coordinating care that it is not just the primary care and the specialist and the case manager or the touches with member services. They like that comprehensive treatment. And obviously we had given more benefits, too. I mean we provide transportation and a lot of other extra services.

Mr. GUTHRIE. OK. Thanks.

Mr. Giese, can you explain what types of choices plans face with the projected cuts under the ACA, what kind of choices will the plans have under these projected cuts?

Mr. GIESE. Plans have a bunch of levers that they have at their disposal to try to ward off these cuts. Those changes or these adjustments include increases in benefits, increases in premiums but of course CMS limits the amount of premiums and benefits they can change in a given year.

They also can try to incorporate more care management programs, but that sometimes is a leap of faith because in their pricing, if they assume a certain level of care management and don't achieve it, it could lead to not successful results.

Plans could exit, they could change their service area, they could limit their network, making it a stronger network with better physicians, more quality care that would help lower their costs as well.

Mr. GUTHRIE. But less choice for the patient?

Mr. GIESE. But less choice for their patients.

Mr. GUTHRIE. So if you like your doctor, you might not be able to keep that?

Mr. GIESE. Correct.

Mr. GUTHRIE. Well, thank you, Mr. Chairman, and I will yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman.

I really appreciate your attendance. It is a great debate. I know there is some diversity of views.

[Slide]

Mr. SHIMKUS. When we talk about budgeting, that is the 2012 fiscal budget. The red is mandatory spending. You will see Medicare is in there. The blue is discretionary budget, which is what we fight and shut down government about. Mandatory spending is spending that we can't control. Medicare is part of that, Medicare, Medicaid, Social Security, interest payments on the debt.

I do this all the time because if you have a national debt, it is based upon mandatory spending and Medicare is part of that actuarial problem that we have for future generations.

Do you know why we are having this debate on Medicare Advantage? The President, through ObamaCare, cut \$716 billion from Medicare. And that is not disputed. Secretary Sibelius was right there. She admitted in testimony to me in front of this committee that she double counted Medicare cuts.

So now we have got to find the money. Now we are going after seniors and programs that—we should have both. We should have traditional fee-for-service for those who want it and we should have the Medicare Advantage plans that we promised them. This is the same debate we had last week on Medicare D. We were able to stop the Administration from hurting seniors and cutting Medicare D program. And so that is why these hearings are very, very important.

And I know it is tough but, you know, facts and numbers are hard to dispute. That is why we are here, because of the attack on seniors from ObamaCare and the cutting of \$716 billion.

Dr. Lew, only 20% of this cut has been actualized right now. My guess is there is still 300 billion more projected to go in the future. What do you think for this big portion of seniors, if that is the true number, what is the future of Medicare Advantage and Mr. Little and the plan and healthcare that he enjoys writing out?

Dr. LEW. Thank you for the question. As I said, we just are starting to feel the pain of the cuts, 20% or less, and as these cuts roll out, it is going to be very difficult and very unlikely that we can continue at the same level of programs and payments to physicians.

Mr. SHIMKUS. So you are saying 300 billion more in cuts, Medicare Advantage might not even be—

Dr. LEW. We are looking at double digit cuts—

Mr. SHIMKUS [continuing]. Available as a program——

Dr. LEW [continuing]. In 2014 plus 2015. I don't see how what we can do can be sustainable.

Mr. SHIMKUS. All right. Let me go quickly because time runs fast. And talk to me about the better healthcare aspects of Medicare Advantage and the diversity of population that you see in Medicare Advantage plans.

Dr. LEW. Better healthcare, you know, we can reduce hospitalizations, readmissions, we get better outcomes, shorter lengths of stay.

Mr. SHIMKUS. Saving dollars?

Dr. LEW. Absolutely saving. I mean investment with a great return. In terms of diversity in the markets that we are in, it is all demographics.

Mr. SHIMKUS. Explain that. I mean it is a senior population so you are——

Dr. LEW. Ethnicities, socioeconomic levels.

Mr. SHIMKUS. Rich, poor, different ethnic backgrounds.

Dr. LEW. Different ethnic backgrounds.

Mr. SHIMKUS. Doesn't discriminate?

Dr. LEW. No. No. It is all comers and it is not one particular demographic.

Mr. SHIMKUS. All right. Let me ask you one more question and no one has raised this, but because of the funding problem, waste, fraud, and abuse is a big aspect on Medicare spending, right? And I have always argued because of fee-for-service, what do we do? We chase costs. We don't manage the illicit theft of the Medicare fund at the point of entry. We have to wait until there is 5, 10 years of data before we go after the provider.

You may not know this but I would like for all of the panel to look at what is a better plan to address the waste, fraud, and abuse that we currently know in Medicare today, especially fee-for-service, and does Medicare Advantage provide a more timely response to fraud? And I think, Mr. Little, you kind of mentioned that, did you not?

Mr. LITTLE. Yes, sir. I get a monthly statement from Humana showing everything I spent and they caution you on the bottom if you have anything that you didn't have done, please call us immediately.

Mr. SHIMKUS. Dr. Lew, do you want to jump in?

Dr. LEW. Yes. I think that is the value of a population-based payment. It is a fixed payment that forces us to manage the care quality, and so we contract with good providers that won't commit fraud, whereas you have got a fragmented fee-for-service that incentivizes volume, a lot of potential for fraud.

Mr. SHIMKUS. I appreciate it. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions.

Mr. CASSIDY. Thank you, Mr. Chairman.

I like Medicare Advantage because I think it aligns incentives. Ms. Stein, I am sure we can find horror stories with fee-for-service Medicare. I am a practicing doctor so I know some of those horror stories. But the nice thing I like is effectively it is a capitated payment which physicians are at risk. If they do what I think Dr.

Lew's organizations do, they go two-sided risk with someone like Humana. So you align incentives and frankly you make money by keeping people out of the hospital and improving outcomes. If you don't, you lose them.

Now, I am struck, Dr. Lew. I am so frustrated I can't open up my email account, but a physician practicing from southern California sent me a document about the dual-eligible project that is happening in southern California. And in this dual-eligible project, so far, there is not a company which is certified. They all have the poor rating for quality and outcomes than the better rating. Now, that is not your organizations. This is something specifically set up for the dual-eligibles.

And speaking to some folks like WellMed out of Austin, Texas, I gather that they selectively go after the dual-eligibles, that they improve outcomes, that they are focusing resources knowing that if not, it breaks the bank. They are a two-sided risk and so with prospective assignment of patients and so that is where they earn the money, keeping that patient out of the hospital and in better health. Would you like to comment on that, please?

Dr. LEW. Yes. Thank you, Mr. Cassidy. That is absolutely correct. In our model we don't make money unless we keep the population healthy. It is very simple.

Mr. CASSIDY. And the patient can change at the end of the year and you have quality indicators, so it is not like if you stiff them, you lose them, and if you stiff them, you get dinged.

Dr. LEW. Right. There is transparency in quality metrics and so members can choose to opt out or switch to another plan.

Mr. CASSIDY. So what percent can you give me of a typical plan that you might represent would be dual-eligibles?

Dr. LEW. Health Net. Is that what you mean? An actual plan?

Mr. CASSIDY. Medicare/Medicaid. Pick a typical plan that if dual-eligibles, would they be 10% of an enrollee group or 15%?

Dr. LEW. OK. I would say out of the senior population it is probably 20%.

Mr. CASSIDY. OK. Now, a lot of these would be in the special needs plans as well?

Dr. LEW. Special needs plan.

Mr. CASSIDY. Now, there has been specific cuts targeted to the special needs plans. I assume that that could in particular negatively impact folks who are most vulnerable. Is that a correct intuition?

Dr. LEW. Definitely. I mean these patients, you know, by definition have more medical problems, chronic illness, chronic disease, and require a lot more intensive management. And so without an infrastructure to take care of them, those are the ones that are really going to be hurt.

Mr. CASSIDY. Well, and my concerns I think in some of the cuts they kind of make the home visit a second-class visit. Again, I treat lot of cirrhotics, and cirrhotics would typically be in a special needs plan. You want to go home and you want to look at their diet and you want to look at their cabinet. You want to see where their salt is coming from. Cirrhotics are very sensitive to salt overload. I kind of like that special needs visit, that home visit which looks at that.

Again, any comments on the impact of decreasing the emphasis upon that?

Dr. LEW. Yes. Well, that is again at a point—home visits for the special needs patient that are bed-bound or home-bound don't have transportation. It is essential that we get to the home and take care of them to look at, you know, cirrhotics that may have fluid overload and you have got to see what they are eating and what their diet is. It is important. You can assess a lot more from a patient in the house than you ever can in the clinic.

Mr. CASSIDY. I once visited a patient of mine and I saw he had a jar of salsa by his bed. I pointed out that salsa has a lot of salt and so, oh, really?

Dr. LEW. Yes.

Mr. CASSIDY. I figure most men are pretty ignorant when it comes to their food and he was a man.

OK. Now, Ms. Stein, you probably disagree with what I have been saying. What are your thoughts?

Ms. STEIN. My experience tells me, as does the research in report by CMS, that people with high medical needs and low income are disproportionately disenrolling from Medicare Advantage plans.

And I don't think I am here to talk about horror stories. As I said earlier, I have no skin in this game. My job is solely to represent low-income—

Mr. CASSIDY. But in fairness, you are mentioning the person who went to Florida and his brain tumor wasn't covered.

Ms. STEIN. One of your colleagues referred to my office and, yes, there are problems in both models. But the point is that we are paying as taxpayers and your colleague earlier put up the pie chart which showed all the cost to Medicare. And the CBO says that we are spending as taxpayers \$150 billion more than we would if these individuals were paid for in traditional Medicare.

Mr. CASSIDY. We can argue about that. I will point out—and I will finish with this, Mr. Chairman—that when Medicaid and Medicare pay differently, it disaggregates payment. When you disaggregate payment, you disaggregate care. So the dual-eligibles are a particular interest of mine. That is why I have been looking at the demonstration projects in southern California. I am very disappointed that the companies that are running this are being rated so poorly, and I do contrast that with some of the folks who are doing kind of subcontracting for Humana and others and just seeing that they are getting superior outcomes. I think that kind of shows you the benefit of the special needs plans in Medicare Advantage.

Ms. STEIN. Actually, I suspect that my organization represents more dually eligible home health and nursing home organizations than anyone in the country. We have about 11,000 open cases right now. I just completed a training seminar with all the home health agencies in Connecticut and one of the questions was do the rules with regard to coverage for home health—these are home health agencies—for people in traditional Medicare also apply for people in Medicare Advantage plans? And I said of course, yes. And there was general agreement in the group of home health agency providers that they have a much greater difficulty getting access to

coverage admission, particularly from the community for people in Medicare Advantage plans——

Mr. CASSIDY. We are out of time——

Ms. STEIN [continuing]. And earlier——

Mr. CASSIDY [continuing]. But let me just say the nice thing about it is that if the beneficiary doesn't like the MA plan, they can change the next year. And that is the wonderful thing about markets. We have to yield back. I am sorry.

Mr. PITTS. The chair thanks the gentleman.

Ms. STEIN. That is only helpful if the person can survive the year and that often doesn't happen.

Mr. PITTS. The gentleman's time is expired.

The chair recognizes the gentleman from New York, Mr. Engel, 5 minutes for questions.

Mr. ENGEL. Thank you very much, Mr. Chairman and Mr. Pallone. Thank you for holding today's hearing.

Let me try to put some things in perspective here. In 2009, prior to the passage of the Affordable Care Act, the rates paid to Medicare Advantage plans exceeded that of traditional Medicare by approximately 18%. The Affordable Care Act required changes to Medicare Advantage payment rates to better align them with the costs associated with traditional Medicare. These changes were estimated by the Congressional Budget Office to save over \$135 billion over 10 years, something that I think my Republican friends would love. The ACA did not make any cuts to the benefits guaranteed to all Americans over the age of 65, whether or not they are in traditional Medicare or Medicare Advantage.

So I think it is worth noting that while Republicans are aghast at this Administration that is moving forward and implementing the provider payment cuts included in the Affordable Care Act, my Republican friends included and voted in support of these very same provider payment cuts and their budget proposals for the last several years. So to act horrified about the changes that are being made to Medicare Advantage now after voting to support them for years strikes me as being disingenuous.

I know in the past there have been concerns about Medicare Advantage plans cherry picking and sticking to enroll the healthiest of seniors leaving sicker beneficiaries enrolled in traditional Medicare. Ms. Stein, in your written testimony you mentioned a 2012 report from CMS that found disenrollment by individuals from Medicare Advantage plans back to traditional Medicare—and I am going to quote what you wrote—"continues to occur disproportionately among high-cost beneficiaries, raising concerns about care experiences among sicker enrollees and increased costs to Medicare."

So let me ask you, given your organization often assists patients when they have issues with the Medicare program, can you elaborate on some of the challenges sicker beneficiaries sometimes have with their Medicare Advantage plans?

Ms. STEIN. Yes, sir. Thank you very much.

As Dr. Van de Water said a little earlier, there isn't a lot of data about actual healthcare outcomes, but we do know about disenrollment patterns, and you just expressed one of them, which is that people at risk, low-income and people who are ill, tend to disenroll from Medicare Advantage plans. And that is because they

have much more difficulty in accessing a variety of specialists, different hospitals where they might get the treatment they want, being able to move around the country to be near their families because there are network limitations, and a variety of other problems.

And we very, very often get calls from people who think that because the program itself is called Medicare Advantage, that they have got something on top of their Medicare. And when they find that they are ill and they need to go see a specialist and the doctor isn't in their network, they are terribly confused and didn't understand that when they enrolled initially.

And while I don't think that Medicare Advantage plans are purposely closing their doors to people with particular conditions, we do know that of the 2,250 doctors and hospitals that were terminated in Connecticut alone, a very small State, this year by an MA plan, a lot of specialists who provide care for long-term illnesses, for instance, nephrologists were on the termination list and particularly in areas of low-income in Bridgeport and other areas in our State leading to significant problems for people who are ill with chronic conditions in MA plans.

Mr. ENGEL. Well, thank you. My home State of New York, which is of course right next to Connecticut, we have countless doctors, hospitals, and health insurance plans that have always made it their mission to provide quality care to all New Yorkers regardless of whether or not their patients have private insurance, Medicaid, Medicare, or pay for their healthcare costs out of their own pockets.

And we also have several Medicare Advantage plans which focus on providing Medicare coverage for the dual-eligible and low-income population in particular, often with more than half of their plan participants eligible for Medicare and Medicaid or receiving a low-income subsidy. Yet an overwhelming number of these plans have found it challenging to achieve the four stars needed to earn a bonus in 2015 despite having scored high on improvement measures.

The let me again ask you, Ms. Stein or Mr. Van de Water, how can we better incentivize Medicare Advantage plans to take on more challenging beneficiaries so that these patients enjoy the same access to high-quality plans and choices available to healthier, more well-off beneficiaries?

Mr. VAN DE WATER. Well, I think the improved risk adjustment, which we have talked about this morning, is actually one of those ways. What we want to do is make sure that health plans are encouraged to attract customers through providing better quality service and not to make money through attracting healthier beneficiaries. So while this has been, you know, criticized on the one hand, actually I think it is a very positive step.

Mr. ENGEL. Thank you. Thank you, Mr. Chairman.

Ms. STEIN. I also suggest that—

Mr. PITTS. The chair thanks the gentleman.

Ms. STEIN [continuing]. I think it was a MedPAC study in March of 2013 that showed that about 20% of dual-eligible special MA plans did score well on the star model rating, and I think that we should look at what they are doing and encourage the other plans

to do that because apparently it is possible to score well on that rating.

Mr. PITTS. The gentleman's time is expired.

Mr. ENGEL. Thank you.

Mr. PITTS. The chair recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman, I would say to you all, and appreciate you all being here. I would say that my 83-year-old mother likes her Medicare Advantage plan. She has had to pay a little bit more for it than she had in some of the previous years. And even though we had Secretary Sebelius here April of last year saying that the plans were costing less nationwide, that hasn't been my mother's experience.

I surveyed, and it was a very small group of constituents in my district that responded, but they responded that theirs were either staying the same or going up. So it does appear that there are some increases. Has that been your experience as well, Mr. Little?

Mr. LITTLE. They didn't increase the base but I have noticed this year that I am paying 25% more for my prescriptions.

Mr. GRIFFITH. OK. I understand that. Mr. Giese, you have been kind enough. I am just wondering if there is something we haven't touched on? I have got some questions for Dr. Lew; I don't have any questions for you, but I thought maybe there was something that you have been sitting here that you wanted to say that you haven't had an opportunity to get out and I am going to give you that opportunity.

Mr. GIESE. No, not really.

Mr. GRIFFITH. All right. I appreciate that. You know, we sometimes have folks here and you have a lot of very good witnesses and then somebody, because of the way the flow of the discussion is going, they get left out and I always hate to see that because I know that your time is just as valuable as everybody else's. So I do appreciate that.

Mr. GIESE. A lot of people have read the report, I can tell, and have quoted it and so—

Mr. GRIFFITH. Very good.

Dr. Lew, according to the CBO, the ACA cut more than \$300 billion from Medicare Advantage programs to spend on new government programs that weren't necessarily for seniors. What types of important health benefits do you think that the MA plans help provide the seniors that would have to be cut if the proposed cuts occur?

Dr. LEW. Well, we have to look at what the investment from prior years did into building up the model—

Mr. GRIFFITH. Yes.

Dr. LEW [continuing]. The coordinator care model and all the additional benefits that the seniors get. And we would have to look at how can we even sustain that with the 10% cuts over the next 2 years? So you are looking at jeopardizing programs, reduced payments to our physicians, and subsequently, it could impact care to the seniors.

Mr. GRIFFITH. Now, I don't know anything about the Connecticut situation, but with those 2,200 some healthcare providers that were eliminated from an MA plan there, is it at least reasonable

to assume that maybe they couldn't afford to pay those doctors the rates that they previously were paying and that maybe one of the reasons—I know it has got to be more complicated than that—but could that be one of the reasons why?

Dr. LEW. That is likely one of the reasons, sure.

Mr. GRIFFITH. Yes. In a recent letter, more than 140 physician groups called on Medicare officials to hold MA rates flat. In the letter they said, “cutting Medicare Advantage year after year will result in deterioration of the care coordination infrastructure and seniors will see a deterioration of benefits, and we are worried we will ultimately move back into fragmented fee-for-service care delivery models. This would be a bad outcome for seniors and a step backward on the healthcare delivery system.” You have been saying the same thing—

Dr. LEW. Saying exactly that same thing, yes.

Mr. GRIFFITH. And can you elaborate on that some?

Dr. LEW. Yes. Well, I think that rather than going backwards is we need to use the platform that we have built to build more, to build more coordinated care. And even some of the newer models within fee-for-service such as ACOs, medical homes, you know, how can we take all that we have learned from the Medicare Advantage coordinated care model, how can we use that to build the newer models that we are trying to do in fee-for-service?

But this impacts all of the healthcare delivery system. It is not just Medicare Advantage. It is care for everybody in the country. And so, you know, if we want to really transform the delivery system, we don't want to touch Medicare Advantage and all that we have built.

Mr. GRIFFITH. All right. I appreciate that very much.

Thank you all again, and, Mr. Chairman, I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, 5 minutes for questions.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

I want to point out that there are a lot of things going on at the same time, additional subcommittee and another committee that I am involved with, so I haven't been here the full time.

But, Mr. Chairman, I would like to ask unanimous consent to insert my opening statement in the record.

Mr. PITTS. Without objection, so ordered.

[The prepared statement of Mr. Waxman follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN

The topic of today's hearing started out as a look at Medicare Advantage. But now we are also considering a hodge podge of GOP bills that do not improve the Medicare Advantage program. I will return to those bills, but first I want to focus on the state of the Medicare Advantage program itself.

In the five years since the enactment of the Affordable Care Act, the Obama Administration has accomplished what the Republicans couldn't accomplish in the 12 preceding years—even with tens of billions of overpayments that drained the Medicare Trust Fund.

As a result of the ACA, the Medicare Advantage program is stronger than ever. Enrollment is at an all-time high and growing, premiums have declined, and benefits have improved along with the health of the Medicare Trust fund—while we have reduced overpayments and improved efficiency.

Chicken Little, the sky is NOT falling.

Mr. Chairman, I want to put a Democratic Staff memo into the record that details this history of exaggerated claims by some in the industry and critics of the ACA.

Since the ACA was enacted, premiums are down by 10% and enrollment is up by 30%. Since CMS released its 2015 payment notice, independent analysts and the financial markets have expressed an optimistic view of Medicare Advantage plans. Insurance company stocks have risen rapidly and Medicare Advantage is poised for growth, even as we gradually reduce the overpayments they have received for years.

Why did the ACA address Medicare Advantage over-payments? At the time, Medicare was paying on average \$800 more per year for beneficiaries enrolled in private plans. Those excess payments drained the Trust Fund and drove up costs for all of Medicare.

Even today, the overpayments are not yet completely phased out, and this year alone Medicare is paying on average 106% more than for care in Medicare Advantage. And as a result, ALL beneficiaries pay higher Part B premium costs.

Seniors also didn't have a lot of confidence in the Medicare Advantage program before the ACA. Too many plan choices made picking one confusing. Differences among plans—on quality or value—were too difficult to discern. Consumer confidence was not strong as patients had no guarantee plans were even spending a minimum amount of their premiums on medical care.

The ACA and the Obama Administration addressed that situation too.

We need Medicare to be solvent for beneficiaries today and in the future. That's what the ACA did, and the Administration should be staying the course to improve quality and value.

Some of the bills considered today turn back the clock on Medicare Advantage.

The two tax bills would encourage healthier and wealthier people to switch to high-deductible health plans for tax sheltering purposes.

Another bill would bar CMS from disapproving private insurance company marketing material—no matter how misleading, incomplete, or biased. A fourth bill would reinstate the second open enrollment period for Medicare Advantage—which was eliminated because it caused confusion for beneficiaries. And finally one of the bills eliminates the ACA's cost sharing reductions, which provide critical protections for lower income Americans, with the vague goal of giving those funds to Medicare Advantage plans.

All of these bills have significant problems and I cannot support them as drafted.

I hope today's hearing takes an honest look at the healthy state of the Medicare Advantage program. Demonizing the Affordable Care Act and falsely claiming that the sky is falling is not a productive use of our time.

Mr. WAXMAN. And there is an awful lot of fear-mongering going on about Medicare Advantage program and it is not based on the facts. The Democratic staff released a memo this morning. The first one is that independent analysts and the financial markets do not agree with the industry's dire claims about the future of Medicare Advantage. And then the second point is that this scare campaign is not the first time the industry has cried wolf about commonsense reforms being flat wrong. The memo looks at the facts, not anecdotes or claims by industry-backed groups.

And here are the facts we point out: Since the ACA was enacted, Medicare Advantage premiums are down almost 10% and enrollment is up 30%. After CMS released its payment notice and the industry claimed the sky was falling, independent experts examine the issue and found that the industry was wrong. They predict the future is bright for Medicare Advantage, and as a result, insurer stock rises have risen, not fallen, since the CMS announcement.

And this is not the first time the industry has cried wolf on Medicare Advantage or other commonsense reforms. They said that the ACA would destroy Medicare Advantage but it is stronger than ever. They said the requirement that they pay back rebates if they spend more than 20% of premiums on profits and overhead would put patients at risk and it did not. Instead, it has resulted in more than \$1.5 billion in rebates and \$5 billion in lower premiums.

Mr. Chairman, I would like to ask unanimous consent to insert the memo I referred to in the record.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. WAXMAN. And the next thing I want to ask in the time I have is, Mr. Van de Water, we have heard a lot today about the Medicare Advantage changes in the Affordable Care Act. These changes strengthen the program in my view and help to improve the solvency of the Medicare trust fund as well preserving Medicare's health for a number of years. If you listen to my colleagues on the other side of the aisle, you would think these cuts were killing the program, but in fact, this has not been the case. Could you comment on what has happened in Medicare Advantage enrollment and premiums since the Affordable Care Act was enacted?

Mr. VAN DE WATER. Yes, Mr. Waxman, I would be happy to. In fact, in my prepared statement I cite some of the same figures that you have just reiterated about how enrollment has indeed grown over the past several years and how premiums have actually gone down. And you are absolutely right that the efficiencies in Medicare payments that were enacted as part of the Affordable Care Act had indeed made an important contribution to strengthening Medicare's Hospital Insurance trust fund. My recollection is that the CBO estimate is that the Affordable Care Act extended the life of the Hospital Insurance trust fund by roughly 8 years.

Mr. WAXMAN. Well, if the health insurance companies like getting more money and the 30% of beneficiaries who are in these plans are generally happy, why not keep overpaying them?

Mr. VAN DE WATER. Well, one of your colleagues on the other side of the aisle showed a chart a few minutes ago showing that, you know, Medicare, as we all know, is a substantial part of the federal budget and we are concerned about reducing projected large deficits. So we—

Mr. WAXMAN. Well, that gives us ideas about how we should make the elderly pay more for their healthcare costs but they don't want to reduce the cuts of overpayments to these Medicare Advantage plans.

We have heard a great deal about ObamaCare cuts to Medicare Advantage, but didn't the Republican budget led by Representative Paul Ryan include the very same so-called cuts that were in the Affordable Care Act?

Mr. VAN DE WATER. Yes, it did.

Mr. WAXMAN. I have been in Congress for 40 years. That is why I am retiring, among other reasons. And I remember when we first made Medicare managed plans available for Medicare reimbursement if the beneficiary chose to go with such plans. And we had it less than what the fee-for-service would be because they selected out some of the lowest risk people and the fee-for-service were covering the highest risk. We went from a little less than what fee-for-service was to way more than the fee-for-service without doubt in my opinion as I look at this program.

Medicare Advantage is important. It serves a very useful purpose to beneficiaries free to choose it and many of them are very happy, but that is just not a reason to overpay them.

Thank you, Mr. Chairman. I yield back my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much. And I have been going back and forth as well from CMT, but this is a very important hearing.

Mr. Giese, 40 to 45% of my seniors in my district—and I have over 100,000 seniors in the Tampa area; I represent an area, the 12th Congressional District of Florida—on Medicare Advantage, 40 to 45%. That is higher than the national average. So, they really love their plans, and they love the fact that they have all these choices.

I am concerned with some of the changes that CMS is doing to their risk model. It seems to me that CMS is ignoring or not factoring in certain chronic conditions when determining their risk model. When considering the risk adjustments, CMS seems to ignore or not count patients with certain chronic conditions. What is the impact of the 2014 changes to the risk model on sick and frail Medicare beneficiaries and particularly to those on the Special Needs Plans area?

Mr. GIESE. Well, changes to the risk model result in reductions in payments to plans, which means the plans have to react by increasing benefits to everyone, but in particular to the poor and actually sicker people who pay the cost-sharing. So these people have to pay more as a result of changes to the risk adjustment model.

Mr. BILIRAKIS. Thank you. The next question is for Dr. Lew. In the 2015 Advance Notice, CMS eliminated the home health assistance assessments as part of the risk model. As I understand their change, CMS would only count the diagnosis identified in a home visit if and when it was confirmed in a later in-office doctor's visit. Can you explain the dangers of the payment change related to the home-based health assessments, especially for the elderly?

Dr. LEW. Yes, thank you. As I had mentioned, home visits are part of the continuum of care and you take out home care and the benefits, it leaves a gap. If you are only going to count a visit or a diagnosis obtained at a visit if the patient is followed up in the office, a lot of these patients go to the hospital because, you know, that is the value of going to the home, early detection, catching something as opposed to a 911 phone call and something a lot more serious. The patient can be sent to the hospital for care.

So, you know, to only count a diagnosis where the patient has a follow-up visit in the doctor's office, that is very narrow in scope and it really discounts the advantage and the benefits of a home visit.

Mr. BILIRAKIS. Thank you very much.

Mr. Giese, this question is for you. For all these cuts to Medicare Advantage, these plans are dependent on the Star Ratings to survive. However, it seems to me that Special Needs Plans may be disadvantaged because of their unique population. Can you describe some of the challenges that Special Needs Plans face in the Star Rating program?

Mr. GIESE. Sure. First of all, a lot of the star ratings are based on survey data and sometimes it is hard to get to these people. Some of them are homeless, some of them, they don't know where they live. So it is hard to find them in these surveys. So special

needs plans tend to have lower star ratings because we can't find the people and they don't respond well to the survey as well.

Mr. BILIRAKIS. OK. Now, for Dr. Lew and Mr. Giese again, if the proposed cuts occur, what kind of benefits would no longer be provided to seniors in your opinion, an example of some of the benefits that they might lose if the cuts take place?

Dr. LEW. Well, from our delivery side, you know, I think you are going to jeopardize all of the extra home visits perhaps. I mean that would be one example. I mean we have a lot of programs built around, again, the continuum of care, visits from pharmacists and social workers, which have sufficient costs. And, you know, if we are on a budget and our revenue is reduced, that is obviously going to jeopardize a lot of our programs.

Mr. GIESE. Remember that cuts and benefits are not just additional benefits over Part A and B; they are also changes in cost-sharing. So if the plan has to increase their cost-sharing, that is a reduction in benefits.

Mr. BILIRAKIS. OK. Very good. Thank you very much. I appreciate it.

I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. That concludes the questions from the Members who are present. There are several committee meetings going on so other Members will have questions. We may have follow-up questions. We will submit those to you in writing. We ask that you promptly respond.

And I recognize the ranking member for a UC request.

Mr. PALLONE. Mr. Chairman, I would just ask unanimous consent to submit for the record some Democratic comments in a letter to CMS.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you.

Mr. PITTS. Thank you very much for your testimony. This is a very important issue and we appreciate you coming today.

And I remind Members that they have 10 business days to submit questions for the record. Members should submit their questions by the close of business on Thursday, March 27.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:18 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Today we examine the future of the popular Medicare Advantage program under the president's health care law. Before this law passed, the president repeatedly promised, "If you like your health care plan, you will be able to keep your health care plan, period. Nobody is going to take it away from you, no matter what." Unfortunately, many seniors who like the Medicare Advantage plan they have, are joining the millions of Americans who have learned the hard way that this is a promise the president cannot keep.

The president's health care law raided more than \$700 billion from Medicare to spend on new government programs that do not improve health care for seniors. More than \$300 billion of this came from the Medicare Advantage program. These cuts threaten the high quality, affordable health coverage that seniors enjoy. As numerous media outlets have already reported, Medicare Advantage plans have been forced to reduce seniors' benefits, increase their premiums, and reduce plan offerings in light of these cuts. Sadly, the situation is only going to get worse as only

about 20% of the health law's cuts to Medicare Advantage have already been realized, with significant cuts in the hundreds of millions of dollars still on the horizon.

According to Medicare data, in 2014 Medicare Advantage enrollment will total approximately 15 million enrollees—roughly 29% of seniors in Medicare. The MA program also enjoys high popularity among seniors, evidenced by CMS' figures that MA enrollment as a percentage of total Medicare enrollment has increased by 173% over the past 10 years.

Medicare Advantage provides millions of seniors better health care than traditional Medicare. MA plans provide seniors a cap against unlimited cost-sharing in the case of catastrophic medical event or hospitalization. The plans provide seniors coordinated care with medical teams working together, provide disease management programs, hotlines to access medical advice, and tools to help better manage chronic disease. All of these are benefits that traditional Medicare does not offer its patients. As a result, it is no surprise that studies and clinical research shows that seniors with MA plans have lower rates of hospitalization and emergency department utilization.

Surveys also confirm that seniors are happy with their high quality, affordable Medicare Advantage options. Seniors who have MA plans they like should be able to keep them—just as the president promised so many times. Today, we will hear from witnesses on this important issue, including several of my colleagues who have brought forth ideas to improve the MA program and keep the promise to seniors. I appreciate their work.

I want to thank Rep. Dennis Ross for his bill, H.R. 4180, which would permit rollovers from health savings accounts to Medicare Advantage savings accounts.

I want to thank Rep. Erik Paulsen for his bill, H.R. 4177, which would allow Medicare beneficiaries participating in a Medicare Advantage savings account to contribute their own money to such an account.

I want to thank Rep. Keith Rothfus for his bill, H.R. 3392, which would restore the Medicare Advantage open enrollment period that existed prior to the health law. This will once again allow seniors to try out their newly selected plan from January to March and make one switch if they discover the selected plan is not meeting their needs.

I want to thank committee member Rep. Gus Bilirakis for his bill, H.R. 3392, which would establish a patient-assignment program in MA and Part D drug plans to protect patients who have demonstrated drug-abuse behavior and would help prevent drug diversion.

I want to thank Rep. Jackie Walorski for her bill, The Advantage of Medicare Advantage for Minorities and Low-Income Seniors Act, which would require the Government Accountability Office to use data reported to the government to produce a study showing how the Medicare Advantage program is particularly beneficial to participants of lower-income and ethnic or racial minority status.

I want to thank Rep. Bill Johnson for his bill, H.R. 4196, which would eliminate Obamacare's cost-sharing subsidies and reinvest the savings from that policy in the Medicare Advantage program.

I want to thank Rep. Jeff Denham for his bill, H.R. 4201, which would enable Medicare Advantage plans to inform potential enrollees of how Obamacare's cuts to the program may impact their choices of plans.

I commend all of these members for their contributions in the effort to keep the promise to America's seniors.

Congress of the United States
Washington, DC 20515

February 28, 2014

Ms. Marilyn Tavenner
Administrator & Chief Operating Officer
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner:

As members of the U.S. House GOP Doctors Caucus, we are a unique voice in Congress for the experiences of physicians and nurses and the needs of patients across the country.

We strongly support Medicare Advantage (MA) as a valued program that improves the health of America's seniors and lowers health care spending. We are concerned with Centers for Medicare & Medicaid Services (CMS) cutting MA program funding in the 2015 Advance Notice by at least 5.9%, which was released on February 21, 2014.


These proposed cuts would be in addition to the severe 2014 cuts made by CMS that are causing disruption for seniors currently. Although seniors consistently report high satisfaction with the MA program, CMS imposed a 6.7% funding cut in the 2014 Final Call Letter. This is in addition to the Patient Protection and Affordable Care Act, which cuts \$200 billion from MA. As a result, MA beneficiaries face higher out-of-pocket-costs, limited access to providers, and reduced benefits this year alone. Further, 5% of MA plans withdrew from the market - the first market exit in nearly five years.


With 40% of MA beneficiaries having annual incomes of less than \$20,000, they cannot bear additional cuts. The MA program helps providers coordinate care for patients through innovative programs that manage complex chronic conditions, promote wellness and prevention, and deliver other benefits beyond those available under fee-for-service Medicare.

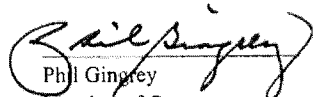
In MA, medical professionals deliver higher quality care using tools that enhance patient-provider communications, reducing hospitalizations by over 20% and individual patient health care costs by over \$10,000 each year. Through heightened collaboration, providers identify treatment gaps and deliver needed follow-up care to MA beneficiaries, decreasing emergency department visits by 20 to 30%.

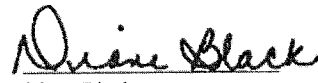
Seniors deserve stability and consistency in their MA benefits. We strongly urge you to keep 2015 MA payment rates flat to ensure that the 15 million seniors enrolled in MA will continue to receive uninterrupted access to these health care benefits - America's seniors are counting on us.


Sincerely,

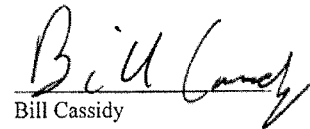

 Renee L. Ellmers
 Member of Congress



 Phil Roe
 Member of Congress

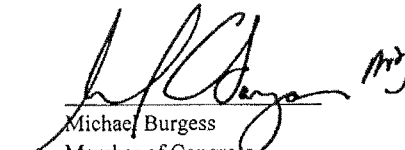

 Phil Gingrey
 Member of Congress

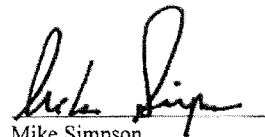

 Diane Black
 Member of Congress

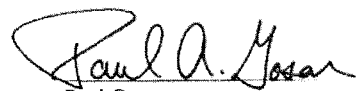

 Charles Boustany
 Member of Congress



 Bill Cassidy
 Member of Congress

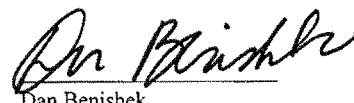

 Paul Broun
 Member of Congress



 Michael Burgess
 Member of Congress



 Mike Simpson
 Member of Congress



 Paul Gosar
 Member of Congress

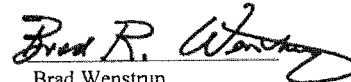

 Andy Harris
 Member of Congress



 Dan Benishek
 Member of Congress



Joe Heck
Member of Congress


Scott DesJarlais
Member of Congress


Tim Murphy
Member of Congress


Brad Wenstrup
Member of Congress


Larry Buschon
Member of Congress


John Fleming
Member of Congress

Congress of the United States
House of Representatives
Washington, D.C. 20515

March 13, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Administrator Tavenner:

Since the passage of the Affordable Care Act (ACA), the Medicare Advantage (MA) program has increased in strength. Enrollment is up by one-third, premiums are down by nearly nine percent, quality is improving, and 99 percent of beneficiaries have access to a plan. The ACA worked to rein in overpayments, which lowered Part B premiums for all Part B beneficiaries and extended Medicare trust fund solvency, and it added new benefits to Medicare. With approximately 70 percent of beneficiaries remaining in traditional Medicare, it is important to balance the needs of all beneficiaries and taxpayers as one evaluates current law and any changes.

The “Advance Notice of Methodological Changes for Calendar Year 2015 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter (“the 2015 Advance Notice and draft Call Letter”) advances the important improvements made by the ACA and proposes further beneficiary protections. We support many of the provisions in the Advance Notice and Draft Call Letter, in particular those that provide greater value to beneficiaries and taxpayers. We are writing to highlight a few of the policies that we hope the Agency will retain in the final rate notice and call letter, while also asking for your consideration of several targeted concerns.

Proposed Payment Rate For 2015

We continue to believe that removing plan overpayments is the right policy course for Medicare and the nation. To reverse course would raise costs for taxpayers and all Part B beneficiaries, drain years from Trust Fund solvency, and expand beneficiary inequities that disadvantage the overwhelming majority of Medicare beneficiaries who remain in fee-for-service.

Lowering MA Payments Based on Fee-for-Service Rates

The MA payment growth rate is a result of a statutorily-required formula that bases MA payments on overall Medicare costs, which have grown more slowly in recent years. There has been a slowdown in Medicare spending growth in recent years, which is to be applauded; the

The Honorable Marilyn Tavenner
 March 13, 2014
 Page 2

impact on rates should not be a surprise to plans. Insurers that choose to offer Medicare plans should not be insulated from market forces that are slowing the rate of growth of health care costs. Indeed, private plans often claim they are more effective than traditional Medicare at cost containment. We encourage CMS to continue to monitor the effect of these payment changes on beneficiary care and access.

Improving Accuracy of MA Risk Adjustment Payments

In compliance with statutory requirements, CMS proposed to apply a 5.16 percent downward adjustment to account for diagnostic coding differences between MA plans and fee-for-service providers. This adjustment reflects the fact that private plans code the health risk of their plan members more aggressively than fee-for-service providers, which makes MA beneficiaries look sicker than similarly situated beneficiaries in traditional Medicare. We recognize that there is strong policy justification to go even further, with the Government Accountability Office reporting to some of the signers of this letter last year that an improved methodology would justify even larger reductions to account for diagnostic coding differences between MA and FFS. We note that the President's budget also proposes a larger adjustment.

CMS exercised restraint in limiting the coding intensity adjustment to the lowest amount required by law. The agency also took other steps that were favorable to the plans by delaying a further phase-in of risk adjustment changes and proposing to use two years (2012 and 2013) of risk scores to calculate the annual trend of risk score growth, which accounts for the increasing population of baby boomers entering Medicare in a way that adjusts for risk score trends that is more favorable to the plans. This combination of policy decisions was in the plans' favor, and should be viewed as mitigating the rate changes required by the statute for 2015.

Excluding Health Risk Assessment Diagnoses from Payments

We support the proposal to exclude for payment purposes diagnoses identified during a home visit assessment that are not confirmed by a subsequent clinical encounter. However, we believe that home visits have the potential to improve care, when a beneficiary receives appropriate follow-up treatment, so we urge CMS to proceed with caution in the final operation of this proposal to ensure that it does not minimize the value of home visits. Home visits with proper clinical follow-up are an important tool to identify and serve the needs of MA enrollees; home visits should not be used merely to maximize reimbursement. Finally, we support CMS' proposal to use the Encounter Data System as an additional source of diagnoses data to calculate 2015 risk scores. We encourage CMS to continue to explore additional ways to improve the MA risk adjustment and ensure payment accuracy.

Protecting Beneficiaries

While some interested parties are solely focused on the rate changes proposed for 2015, we believe it is important to acknowledge and applaud the consumer protections proposed this year. It is important to note that the ACA improved Medicare's benefits, including those offered

The Honorable Marilyn Tavenner
 March 13, 2014
 Page 3

by MA plans. Non-Medicare covered benefits, which are offered at the plan's discretion, have frequently changed from year-to-year, even prior to the ACA.

Protecting Beneficiaries from Cost Increases

We support CMS' proposal to again use its authority granted in the Affordable Care Act to protect beneficiaries from significant increases in costs or cuts in benefits. We are pleased to see that CMS is proposing to reduce the permissible amount of increase in total beneficiary cost to \$32 per member per month and retain the current limits on beneficiary out-of-pocket spending. We recognize that plans need the flexibility to manage rate changes but believe they are able to, and should, do so without increasing burden on beneficiaries. For example, plans could reduce executive compensation or marketing expenses, among other options.

We also support the proposal to clarify guidance to indicate that beneficiaries' contributions toward these out-of-pocket spending limits are transferable when they move to any other plan, regardless of type, offered by the same MA organization.

Protecting Beneficiaries from Changes in Provider Networks

We are heartened to see the array of policy ideas the agency is considering to protect beneficiaries from unexpected changes in provider networks and encourage you to move forward on these program improvements for 2015 and subsequent years. We support the proposal to require Medicare Advantage Organizations (MAOs) to notify CMS of major network changes and provide a written plan of how the MAO will ensure enrollees can locate new providers, including how the plan will ensure continuity of care. As discussed in the Call Letter, we also strongly encourage CMS to use rulemaking to require plans to provide beneficiaries more advance notification when providers are being terminated from the plan network, to notify beneficiaries of other provider options, and to limit the ability of plans to terminate provider contracts without cause during a plan year. We point out that any notification to beneficiaries of other provider options should be sure to flag providers accepting new patients, otherwise such notice is meaningless. We also support the proposal to strengthen requirements in the Annual Notice of Change (ANOC) so that beneficiaries are explicitly told by their plan of their rights if a provider is terminated during the year. Finally, we encourage you to consider whether beneficiaries adversely affected by network changes mid-year ought to be permitted a special enrollment period (SEP) or, as part of continuity of care requirements, provided out-of-network care at in-network levels while finishing a course of treatment.

Innovations in Health Plan Design

We note that the Call Letter states CMS is looking to partner with private payers to test innovations in health plan design, including so-called "value-based" arrangements. While value based insurance design (VBID) might be a tool to help steer beneficiaries to clinically effective care, we are extremely worried that plans can use VBID to alter cost-sharing to further segment risk and cherry-pick among beneficiaries. MA plans have a history of using benefit design to attract healthier and less costly beneficiaries, and CMS oversight is often hampered by

The Honorable Marilyn Tavenner
 March 13, 2014
 Page 4

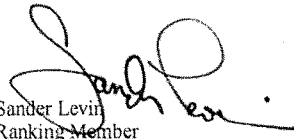
inadequate resources. We urge CMS to use extreme caution in testing this model so that plans are not given another tool to favorably select among beneficiaries.


Star Ratings Program

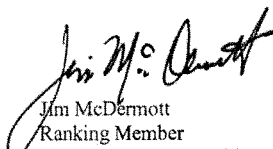
We recognize that constructing the Star Ratings program is a delicate balancing act between appropriately rewarding consistently high-quality plans while providing financial incentives to plans that are steadily improving. We read with interest CMS' discussion of plans seeking special allowance in the Star Ratings program for serving a large number of low-income beneficiaries or other special needs plan (SNP) populations. In that discussion, CMS rejected the notion of a correlation between SNP enrollment and lower star ratings. We agree that these plans must be held to the same high standards as all plans. However, we have recently seen data from several plans indicating there may be an inverse relationship between the percent of plan membership that is low-income and its star ratings, with plans serving more low-income beneficiaries receiving fewer stars on the rating system. We ask you to take another look at the data to ascertain whether plans serving high numbers of low-income beneficiaries consistently fare less favorably in the star rating system, and if so, to explore the reasons why and whether there is an appropriate solution that would better reflect quality ratings and encourage continued improvement in those plans.

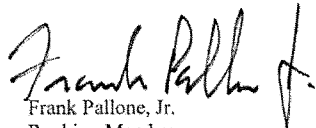
In closing, we believe that many of the policies proposed by CMS on January 10 will continue to improve the Medicare program. We encourage you to continue your work to strengthen Medicare for beneficiaries and taxpayers. We urge you to reject calls to weaken this regulation. Thank you for your hard work.

Sincerely,


 Sander Levin
 Ranking Member
 Committee on Ways and Means


 Henry A. Waxman
 Ranking Member
 Committee on Energy and Commerce


 Jim McDermott
 Ranking Member
 Subcommittee on Health
 Committee on Ways and Means


 Frank Pallone, Jr.
 Ranking Member
 Subcommittee on Health
 Committee on Energy and Commerce

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

March 13, 2014

To: Committee on Energy and Commerce Democratic Members and Staff
Fr: Committee on Energy and Commerce Democratic Staff
Re: Insurance Industry Claims Regarding Reforms to Medicare Advantage

On February 27, 2014, America's Health Insurance Plans (AHIP), the national trade association representing the health insurance industry, released a report on the purported impact of recent reforms to the Medicare Advantage (MA) program. The report claims that this year's proposed changes to the payment methodology used by the Center for Medicare and Medicaid Services (CMS) will cause seniors "to face higher costs and lose benefits and choices upon which they rely today."

Analyses by independent experts, financial analysts, and even some individual health insurance companies have reached very different conclusions about the impact of the payment reforms on beneficiaries and the insurance industry itself. This memorandum puts the recent AHIP analysis in context by presenting the views of other experts and stakeholders. It also examines AHIP's record of making exaggerated claims about the impacts of federal policies.

I. The AHIP Report

On February 27, 2014, AHIP released a report entitled "2015 Advance Notice: Changes to the 2015 Medicare Advantage Payment Methodology and the Potential Effect on Medicare Advantage Organizations and Beneficiaries."¹ The report addressed the reforms to Medicare Advantage enacted in the Affordable Care Act to reduce overpayments to Medicare Advantage

¹ America's Health Insurance Plans, *2015 Advance Notice: Changes to the 2015 Medicare Advantage Payment Methodology and the Potential Effect on Medicare Advantage Organizations and Beneficiaries* (Feb. 27, 2014) (online at <http://www.ahip.org/2015-Advance-Notice/>).

plans, the annual fee on health insurance companies, the risk adjustment methodology used in Medicare Advantage, and the estimated per beneficiary costs of providing Medicare services.

AHIP concluded that Medicare Advantage plans would see a total payment reduction of 5.9% in 2015. The AHIP report claims that these estimated reductions would lead to premium increases or benefit changes of \$35 to \$75 per month for Medicare Advantage enrollees. The report claims that this “could result in a significant amount of upheaval in the MA market that will likely affect virtually all of the approximately 15 million Medicare beneficiaries enrolled in [Medicare Advantage plans]. This includes the potential for plan exits, reductions in service areas, reduced benefits, provider network changes, and reduced MA enrollment.” The report predicts these impacts will disproportionately affect low-income beneficiaries and other vulnerable populations.

II. Independent Assessments of Medicare Advantage Reforms

Since the release of CMS’s 2015 payment notice, analyses by independent experts, financial analysts, and individual health insurance companies have reached significantly different conclusions about the Medicare Advantage reforms than the AHIP report. These independent analyses have found that Medicare Advantage enrollment will continue to grow, that insurers’ Medicare Advantage businesses remain highly profitable, and that many of the reforms announced by CMS will be positive for Medicare Advantage plans. Financial markets appear to have found these analyses more credible than AHIP’s claims, with many insurance company stocks rising significantly in recent days.

A Barclays analysis found that similar rate changes from 2009 through 2014 have not adversely affected MA plans because “MA plans have been able to grow membership an aggregate 4.7 million lives or 41%.” Barclays noted that even after CMS’s reforms go into effect, Barclays expects Medicare Advantage enrollment growth of 3% to 5% in 2015. Barclays also noted that “managed care plans have many levers they can pull to further maintain profit margins.”²

JP Morgan and health insurer Humana both estimated that the actual reduction in overpayments to Medicare Advantage plans would be approximately 4% in 2015, approximately one-third less than the reduction AHIP claimed. JP Morgan released an analysis stating that the bank “maintain[s] our positive long-term view of Medicare Advantage” and touted Medicare Advantage plans’ “long term revenue growth potential.”³ JP Morgan also noted that some of the largest health insurers have seen better than expected financial returns in recent years, noting “better growth than initially expected at [Humana], [Aetna], and [HealthNet], [and] growth instead of initially expected attrition at [Wellpoint].”⁴ A financial journalist commented that

² Barclays, *2015 Prelim MA Rates Better than Worst Case, but Will Be More Plan Specific* (online at <https://live.barcap.com/PRC/servlets/dv.search?contentPubID=FC2012232&bclink=decode>).

³ J.P. Morgan, *Medicare Advantage, 2015 Rates Better than Expected at -4% as FFS Normalization Offsets Negative Trend Adjustments* (Feb. 24, 2014).

⁴ *Id.*

“Medicare Advantage plans have long been regarded as a major growth engine, as more baby boomers reach 65, qualifying for the program.”⁵ As a result, major health insurers like Humana, Aetna, and United Health saw their stock prices rise rapidly in the days following the CMS announcement.⁶

Prior to passage of the Affordable Care Act (ACA), Medicare Advantage plans were paid significantly more per beneficiary than the cost of coverage under traditional Medicare. Medicare Advantage rates exceeded traditional Medicare spending by an average of 18% in 2009, costing taxpayers \$800 more per beneficiary than traditional Medicare and raising premiums for traditional Medicare beneficiaries.⁷

These overpayments had multiple adverse impacts. Numerous independent observers including the Medicare Payment Advisory Commission (MedPAC), the Government Accountability Office (GAO), and the Congressional Budget Office (CBO) have noted repeatedly that these significant overpayments increase premiums in traditional Medicare, weaken the financial health of the Medicare program, and increase the federal budget deficit.⁸ They also do not appear to improve health outcomes or the quality of care. Despite these excessive costs, numerous independent analyses demonstrated that Medicare Advantage beneficiaries did not see lower out-of-pocket costs or receive higher quality care than traditional Medicare beneficiaries.⁹

⁵ Barron’s, *Humana, Aetna Rally as Medicare Cuts Misinterpreted* (Feb. 24, 2014) (online at <http://blogs.barrons.com/stockstowatchtoday/2014/02/24/health-insurers-rebound-medicare-cuts-not-so-bad/>).

⁶ *Id.*

⁷ The Commonwealth Fund, *Realizing Health Reform’s Potential. The Impact of Health Reform on the Medicare Advantage Program: Realigning Payment for Performance* (Oct. 2012) and Letter from Secretary of Health and Human Services Kathleen Sebelius to Speaker John Boehner (Feb. 21, 2014) (online at <http://democrats.energycommerce.house.gov/sites/default/files/documents/Boehner-HHS-Affordable-Care-Act-Medicare-Advantage-2014-2-21.pdf>).

⁸ Government Accountability Office, *Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk Score Adjustments* (Jan. 31, 2013) (online at <http://www.gao.gov/products/GAO-13-206>); Government Accountability Office, *CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices* (Jan. 26, 2012) (online at <http://www.gao.gov/products/GAO-12-51>); Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2009) (online at http://www.medpac.gov/chapters/Mar09_Ch03.pdf); Congressional Budget Office, *Budget Options, Volume 1, Health Care* (Dec. 2008) (online at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>).

⁹ See e.g. Government Accountability Office, *Higher Spending Relative to Medicare Fee-for-Service May Not Ensure Lower Out-of-Pocket Costs for Beneficiaries* (Feb. 28, 2008) (online at <http://www.gao.gov/products/GAO-08-522T>); Center on Budget and Policy Priorities, *Curbing Medicare Advantage Overpayments Could Benefit Millions of Low-Income and Minority Americans* (Feb. 19, 2009) (online at <http://www.cbpp.org/files/2-19-09health.pdf>);

MedPAC recommended that Congress take action to reduce these overpayments. They recommended that Congress protect taxpayers by tying Medicare Advantage payments more closely to fee-for-service payments and by limiting insurers' ability to reap greater profits and shift costs onto traditional Medicare by enrolling healthier beneficiaries.¹⁰ The Affordable Care Act included reforms similar to the MedPAC recommendations. Under the Affordable Care Act, overpayments to Medicare Advantage plans are phased down, but they have not been eliminated.

This approach has proven successful. Independent analysts and the financial markets have expressed confidence in the continued profitability of Medicare Advantage plans. At the same time, Medicare Advantage enrollment has increased significantly, premiums have declined by 10%, and seniors continue to have broad access to a variety of plans.¹¹ These positive trends directly contradict the dire predictions made by insurers when the Affordable Care Act was enacted.

III. AHIP's Record of Exaggerated Claims

Since before the enactment of the Affordable Care Act, the insurance industry has made numerous claims about the negative impact of the law on Americans with insurance and the finances of the industry. The industry's predictions have been particularly negative and particularly inaccurate about the impact of the law on Medicare Advantage, but the industry has made similarly inaccurate predictions on the impact of a number of provisions in the law. Understanding this record is important for members as they assess the reliability of the industry's current claims about Medicare Advantage.

In 2010, the health insurance industry described the ACA's reforms to Medicare Advantage by saying: "[t]he legislation imposes \$200 billion in cuts to Medicare Advantage that

International Journal of Health Care Finance and Economics, *Nothing for Something? Estimating Cost and Value for Beneficiaries from Recent Medicare Spending Increases on HMO Payments and Drug Benefits* (Mar. 2009) (online at <http://link.springer.com/article/10.1007%2Fs10754-008-9047-x>); Government Accountability Office, *Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk Score Adjustments* (Jan. 31, 2013) (online at <http://www.gao.gov/products/GAO-13-206>); The Commonwealth Fund, *The Impact of Health Reform on the Medicare Advantage Program: Realigning Payment with Performance* (Oct. 16, 2012) (online at <http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Oct/Impact-of-Health-Reform-on-the-Medicare-Advantage-Program.aspx>).

¹⁰ Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2009) (online at http://www.medpac.gov/chapters/Mar09_Ch03.pdf).

¹¹ Kaiser Family Foundation, *Medicare Advantage 2014 Spotlight: Plan Availability and Premiums* (Nov. 25, 2013) (online at <http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/>) and Letter from Secretary of Health and Human Services Kathleen Sebelius to Speaker John Boehner (Feb. 21, 2014) (online at <http://democrats.energycommerce.house.gov/sites/default/files/documents/Boehner-HHS-Affordable-Care-Act-Medicare-Advantage-2014-2-21.pdf>).

will cause massive disruption for the more than 10 million seniors enrolled in the program. If these cuts are enacted, millions of seniors in Medicare Advantage will lose their coverage, and millions more will face higher premiums and reduced benefits.”¹²

Since the ACA was enacted, Medicare Advantage premiums have fallen by 9.8% and enrollment has increased by more than 30% to an all-time high of over 15 million. Over 80% of beneficiaries have access to an MA plan with no premium. The average beneficiary has a choice of 18 MA plans and 99% of beneficiaries have access to at least one Medicare advantage plan. Medicare Advantage plans’ quality ratings have improved: there has been a 28% increase in the number of plans with four or more stars.¹³

In testimony before the Subcommittee on Health, a leading advocate for Medicare beneficiaries stated: “we find that the MA market has vastly improved in recent years as a result of policies advanced by the ACA and CMS to stabilize beneficiary cost sharing, streamline plan choices, and enhance the quality of MA plans.”¹⁴

The industry also made dire claims about the impact of the ACA’s Medical Loss Ratio (MLR), which is the requirement that insurers spend no more than 20% of the premiums they collect on profits and administrative expenses or rebate the excess to their customers. The industry claimed, “The current MLR proposal will reduce competition, disrupt coverage, and threaten patients’ access to health plans’ quality improvement services.”¹⁵ The industry also argued that “the MLR could turn back the clock on ... quality enhancing programs as well as fraud prevention initiatives while potentially inhibiting the next generation of delivery system reforms.”¹⁶

¹² America’s Health Insurance Plans, *End the Health Insurance Tax* (Mar. 18, 2010) (online at <http://www.ahip.org/News/Press-Room/2010/AHIP-Statement-on-Health-Care-Reform-Legislation.aspx>).

¹³ Letter from Secretary of Health and Human Services Kathleen Sebelius to Speaker John Boehner (Feb. 21, 2014) (online at <http://democrats.energycommerce.house.gov/sites/default/files/documents/Boehner-HHS-Affordable-Care-Act-Medicare-Advantage-2014-2-21.pdf>).

¹⁴ House Committee on Energy and Commerce, Subcommittee on Health, Testimony of Joe Baker, President, Medicare Rights Center, *Hearing on Medicare Advantage: What Beneficiaries Should Expect Under the President’s Health Care Plan* (Dec. 4, 2013).

¹⁵ America’s Health Insurance Plans, *AHIP Statement on MLR* (Oct. 21, 2010) (online at [http://www.ahip.org/News/Press-Room/2010/AHIP-Statement-on-MLR\(2\).aspx](http://www.ahip.org/News/Press-Room/2010/AHIP-Statement-on-MLR(2).aspx)).

¹⁶ America’s Health Insurance Plans, *AHIP Statement on the Medical Loss Ratio Requirement* (Apr. 26, 2012) (online at <http://www.ahip.org/News/Press-Room/2012/AHIP-Statement-on-the-Medical-Loss-Ratio-Requirement.aspx>).

None of this has happened. In the first two years the MLR was in effect, insurers paid out \$1.5 billion in rebates – giving the average family a rebate of \$100.¹⁷ Insurers have become more efficient, cutting their administrative costs and giving consumers better value for their premium dollar. In total, the ACA’s medical loss ratio requirement has helped save consumers \$5 billion through lower premiums and rebates.¹⁸ There is no evidence that the MLR is reducing fraud fighting efforts or harming quality improvement efforts.

The industry’s claims about the impact of the annual health insurance fee have been similarly negative. AHIP claimed that the fee is “a massive new sales tax on health insurance which will increase the cost of coverage for individuals, small businesses, and public program beneficiaries.”¹⁹ An advocacy group aligned with the industry claimed that the fee “[s]ignificantly raises small business costs and creates considerable uncertainty about the future.”²⁰

Independent analyses have come to the opposite conclusions. A RAND Corporation study found that “small group premiums ... will be unchanged by the law.”²¹ A 2011 report by the Urban Institute found that “employers with fewer than 50 employees are expected to experience substantial savings on health care costs due to the benefits of the health insurance exchanges and subsidies for the smallest firms.”²²

When the law was enacted, the Congressional Budget Office did not predict significant premium increases in the small group market.²³ Since then, CBO has found that premiums in the individual market are lower – not higher – than CBO estimated. In fact, premiums in the new

¹⁷Center for Medicare and Medicaid Services, *80/20 Rule Delivers More Value to Consumers in 2012* (June 20, 2013) (online at <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf>).

¹⁸ *Id.*

¹⁹ America’s Health Insurance Plans, *End the Health Insurance Tax* (Mar. 18, 2010) (online at <http://www.ahip.org/News/Press-Room/2010/AHIP-Statement-on-Health-Care-Reform-Legislation.aspx>).

²⁰ *Stop the HIT* (online at <http://www.stopthehit.com/home>).

²¹ RAND Corporation, *The Affordable Care Act and Health Insurance Markets; Simulating the Effects of Regulation* (2013) (online at http://www.rand.org/content/dam/rand/pubs/research_reports/RR100/RR189/RAND_RR189.pdf).

²² Urban Institute, *The Effects of Health Reform on Small Businesses and Their Workers* (June 2011) (online at http://www.smallbusinessmajority.org/_docs/resources/Urban_Small_Biz_Report.pdf).

²³ Letter from Congressional Budget Office Director Douglas Elmendorf to Senator Evan Bayh (Nov. 30, 2009) (online at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf>).

health insurance marketplaces are 16% below CBO estimates.²⁴ Expert independent analyses have reached similar conclusions. The Kaiser Family Foundation concluded: “While premiums will vary significantly across the country, they are generally lower than expected ... suggesting that the cost of coverage for consumers and the federal budgetary cost for tax credits will be lower than anticipated.”²⁵

IV. Conclusion

The Affordable Care Act has required reforms in the insurance industry that lower costs and improve the quality of care. In every instance, the insurers have a choice of how to comply. The companies can decide whether (1) to raise costs on their customers, (2) to reduce their costs by becoming more efficient, or (3) to reduce their substantial profit margins. Consistently, the insurers have found ways to comply with the new requirements of the Affordable Care Act without raising costs to consumers. The evidence suggests that they are likely to continue to be able to do so in the future. The leading insurance companies have multi-billion dollar annual profits, their stock prices have risen substantially in recent years, and they expect significant growth in customers and revenues in the coming years.²⁶

²⁴ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace Premiums for 2014* (Sep. 2013) (online at http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_marketplace_premiums.cfm).

²⁵ Kaiser Family Foundation, *An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014* (Sep. 2013) (online at <http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf>).

²⁶ See e.g. Forbes, *Despite Glitches, Obamacare Profit Windfall to Insurers Well Underway* (Oct. 26, 2013) (online at <http://www.forbes.com/sites/brucejapsen/2013/10/26/despite-glitches-obamacare-profit-windfall-to-insurers-well-underway/>) and Center for Public Integrity, *Analysis – Health Insurance Corporate Profits Spiked Despite Dire Predictions of Health Care Reform Wreckage* (Apr. 25, 2011) (online at <http://www.publicintegrity.org/2011/04/25/4321/analysis-health-insurance-corporate-profits-spiked-despite-dire-predictions-health>).

April 2, 2014

Mr. Frank Little
Medicare Beneficiary
2837 Rose Garden Way
Virginia Beach, VA 23456

Dear Mr. Little:

Thank you for appearing before the Subcommittee on Health on Thursday, March 13, 2014, to testify at the hearing entitled "Keeping the Promise: Allowing Seniors to Keep Their Medicare Advantage Plans If They Like Them."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Wednesday, April 16, 2014. Your responses should be mailed to Jessica Wilkerson, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to jessica.wilkerson@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr, Ranking Member, Subcommittee on Health

Attachment

Attachment – Additional Questions for the Record for Mr. Little

The Honorable Joseph R. Pitts

1. You've had 3 different MA plans. Do you feel like you have more choices or fewer choices today than 5 years ago when you enrolled?

At 65, I had four Medicare Advantage plans to choose from that were well-known and offered prescription drugs at no additional cost. Now, in Virginia Beach, there is only one of these plans.

2. Under traditional Medicare without a supplemental policy, seniors could face financial ruin due to the unpredictable cost-sharing from unexpected illness or hospitalization. Yet Medicare Advantage plans offer seniors catastrophic protection. Do you feel like your MA plan gives you peace of mind at a low cost?

Most definitely. Medicare Advantage works with the providers and gets the lowest prices for beneficiaries.

3. What would have happened to you if you'd had a health episode and weren't on an MA plan?

Since age 65, I estimate I've had approximately \$750,000 in medical bills. My total out of pocket expenses with Medicare Advantage was about \$500.

4. How would you feel/what would you do if you lost the MA plan you have today?

I don't think I could afford regular Medicare plus adding Medigap to get similar coverage to what I've have with Medicare Advantage.

5. Before Obamacare passed, President Obama told us that Americans who liked the health care plan they had would be able to keep it. However, the Medicare Actuary in 2010 projected that by 2017, enrollment in MA would be about HALF of what it would otherwise be. And we are seeing those cuts take place. So, many seniors who like their MA plan might not be able to keep it. Do you feel like the President kept his word on this issue?

Absolutely not.

6. According to the Congressional Budget Office, Obamacare cut more than \$300 B from the MA program to spend on new government programs not for seniors. Do you think that is fair? How does that make you feel? Do you feel like lawmakers who supported Obamacare are keeping their promise to protect our nation's seniors if they let these cuts go through?

Thankfully my MA plan worked with my providers to lower payment and . But my general physician has said if it's any lower, he will have to drop out of the program as many physicians have already done.

7. Can you describe what your plan has done for you recently that you think may prevented a hospitalization or from returning to the hospital?

Every January, I go to my general physician, cardiologist, and pulmonary doctor, and every five years, my colonoscopy doctor. These visits monitor conditions I have, and helps prevent disease progression and manages my health. This year, my Medicare charges would have been \$975. With Medicare Advantage, my only out of pocket cost was \$35 for the cardiologist.

April 2, 2014

Dr. Mitchell Lew
CEO and Chief Medical Officer
Prospect Medical Systems
1920 East 17th Street, Suite 200
Santa Ana, CA 92705

Dear Dr. Lew:

Thank you for appearing before the Subcommittee on Health on Thursday, March 13, 2014, to testify at the hearing entitled "Keeping the Promise: Allowing Seniors to Keep Their Medicare Advantage Plans If They Like Them."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr, Ranking Member, Subcommittee on Health

Attachment

House Energy and Commerce, Health Subcommittee
Additional Questions for the Record
Answers prepared by Dr. Mitchell Lew

1. *The bipartisan, bicameral SGR bill has pretty strong incentives for physicians to take two-sided risk. Yet the only mature model in Medicare today where physicians truly take risk is in MA. Has the MA model been successful in providing better incentives for physicians and better care for patients? If so, do you think the coming cuts hurt the MA model?*

A: The MA model has definitely been successful in providing better incentives for physicians and better care for patients. An adequately funded MA program is critically important in developing the infrastructure necessary for delivery reform and movement toward coordinated, value-based care. The impending cuts will have a direct and negative impact on the MA model and consequently, MA beneficiaries.

2. *Supporters of Obamacare often like to tout the law's handful of demonstration projects that experiment from capitated payments to providers. Can you talk about what your experience with capitated, accountable physician groups has been, and how it should inform the rest of Medicare? Do you think the goals of the capitation demos are similar to MA?*

A: CAPG members have three decades of experience with capitation payments and the accountable care model it has created. Global capitation is an ambitious goal, but one that most of the American healthcare system should strive for. While the capitation demos are worth conducting, the real focus should be on MA, a proven model with a strong record of success.

3. *Some people suggest insurance companies are overpaid for MA and rates should be cut to fee-for-service levels for "equity." What do you think the impact of that will be on patients?*

A: Eighty-five percent of MA funding is directed toward providers. Those providers and their patients will be severely harmed by cuts to the program. While the ACA now statutorily brings MA to parity with fee-for-service Medicare, that may be short-sighted. Since MA is a proven model and platform for delivery reform across the nation, it deserves investment and promotion.

4. *Would you explain concerns you have with the payment change for CY2015 related to the homebased health assessments?*

A: Homebased health assessments are critical in providing quality care to MA beneficiaries, particularly those that are home or bed-bound. Home visits provide the best opportunity to identify lifestyle hazards, perform medication reconciliation and conduct dietary and nutritional assessments. That type of important information just isn't accessible during office visits.

5. *Only about 20% of the reductions to MA in the ACA have been phased in as of the end of this year. That means the bulk of the \$300 B that is being taken out of the program will be cut in future years. What do you think the future of the program looks like in terms of access to doctors for seniors on MA?*

A: Cuts of that size will inevitably and substantially reduce seniors' access to quality care. CAPG is deeply concerned that additional cuts will place the coordinated care model and infrastructure at risk.

6. *Generally speaking, do you think MA or fee-for-service Medicare is better health care for most seniors?*

A: The MA program unequivocally delivers better care to seniors at lower costs and higher patient satisfaction rates than fee-for-service Medicare. Research shows MA beneficiaries are more likely to get preventative screenings, like mammograms, cholesterol screenings and eye tests for diabetes patients, than those in fee-for-service. MA beneficiaries also tend to have lower rates of preventable readmissions.

7. *Many elderly, frail, low-income individuals who are dually eligible for Medicare and Medicaid, are in special needs plans in the MA program. And at CMS, there is an effort to enroll many other "dual eligibles" in coordinated care plans or plans with capitated payments. From your perspective, would a dual get better care in FFS or MA?*

A: Dual eligibles receive vastly better care in the MA program than they do in traditional Medicare. Duals tend to be sicker individuals with multiple chronic diseases who require a greater level of care coordination. The fragmented system in fee-for-service Medicare is particularly detrimental to those chronically ill patients who greatly benefit from the team-based approach of the MA model.

April 2, 2014

Mr. Glenn Giese
Principal
Oliver Wyman Consulting Actuaries
411 East Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202

Dear Mr. Giese:

Thank you for appearing before the Subcommittee on Health on Thursday, March 13, 2014, to testify at the hearing entitled "Keeping the Promise: Allowing Seniors to Keep Their Medicare Advantage Plans If They Like Them."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr, Ranking Member, Subcommittee on Health

Attachment

Additional Questions for the Record for Mr. Giese

The Honorable Joseph R. Pitts

1. Can you explain why your report projects deeper cuts to Medicare Advantage plans than CMS's estimates?

Response:

I have not seen the CMS estimate to which you are referring. It is possible the estimate reflects the impact only of the preliminary growth rates and does not incorporate other factors such as the continued phase-in of the ACA cuts, the end of the Quality Bonus Demonstration, the impact of the health insurance fee, and other factors outlined in our report. My report analyzes all the factors impacting MA in 2015 including the policies and regulatory changes in CMS' "Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and Draft 2015 Call Letter", cuts included in the Affordable Care Act (ACA), and other legislative provisions addressing MA payments. Specifically, we identified nine different factors affecting MA payments in 2015, most of which would reduce payments. As shown in the table below, we have calculated that the projected overall impact of these policies would be to reduce MA payments by an estimated 5.9 percent in 2015.

Estimated Reduction in 2015 for MAOs

	Reduction (%)
ACA quartile impact for 2015	-2.4%
Change in plans' star rating for 2015	0.4%
Elimination of bonus for 3.0 and 3.5 stars for 2015	-1.9%
Elimination of applicable amount bonus	-0.1%
Ratebook change for 2015	-1.9%
Projected insurer fee for 2015	-0.8%
Coding Intensity change for 2015	-0.25%
Risk score normalization factor for 2015	3.2%
*Elimination of home assessment visit diagnoses	-2.0%
Total Reduction for 2015	-5.9%

2. What are the tools that CMS has at its disposal to *legally* (i.e., other than a nationwide demo) reduce the impact of the cuts in the Advance Notice, through administrative or regulatory means?

Response:

The report is an actuarial analysis of the reduction in payments and the impact on beneficiaries and does not evaluate all the tools and solutions to reduce the impact of the 2015 Advance Notice. However, it is my understanding CMS has wide discretion to establish rates for MA plans in 2015. For example, in the Advance Notice the agency decided to use its discretion to change the way the FFS Normalization Factor is calculated, which we estimate will increase

payments by 3.2%. Other changes include revised estimates to the MA and FFS growth rates, which reduce payments by 1.9%, and CMS' new proposed approach to in-home health risk assessments, which we estimate will reduce payments to MA plans by an average of 2%.

3. What is the impact of the 2014 changes to the risk model on sick and frail Medicare beneficiaries, in particular those in Special Needs Plans?

Response:

The impact of the 2014 MA Risk Adjustment Model reduces incentives for investment by health plans in chronic care management activities on which sick and frail beneficiaries, especially those enrolled in a Special Needs Plan, depend. For example, CMS made significant model changes that place less emphasis on lower stages of Chronic Kidney Disease and Diabetes. This means MA plans that effectively detect beneficiaries with these conditions and invest in care management programs will not be appropriately reimbursed for the investment necessary to implement these activities. It should be noted that CMS proposes in the 2015 Advance Notice that the 2014 Risk Adjustment Model changes would continue to be phased in by blending risk scores for 2014 under the revised 2014 model (75%) and the model that had previously been in place (25%).

4. How severe do you think these cuts are, and when was the last time you saw cuts of this nature— what was the impact on the program in terms of enrollment, stability, plan participation, etc.?

Response:

The last time cuts of this magnitude occurred was after enactment of the Balanced Budget Act of 1997, when enrollment in Medicare Advantage (then known as Medicare+Choice) experienced multi-year reductions in enrollment. As my report indicates, between 1999 and 2003 Medicare+Choice enrollment declined from 6.2 million to 4.7 million. This past history demonstrates it is likely that the continued erosion of funding would eventually lead to increased costs for beneficiaries and reduced access to MA plans.

5. When Obamacare passed, the Medicare actuary projected the impact of the MA cuts: “We estimate that in 2017, when the MA provisions will be fully phased in, enrollment in MA plans will be lower by about 50 percent (from its projected level of 14.8 million under the prior law to 7.4 million under the new law).” According to my calculations, only about 20% of the more than \$300B in cuts to MA that the CBO projects have been phased in this year. So is it safe to say that the worse is yet to come?

Response:

Yes, the ACA cuts are back loaded and the vast majority has not yet taken effect. Only about 10% of the cuts CBO originally projected will have gone into effect by the end of 2013 with another 10% implemented this year. In addition to these cuts, the American Tax Relief Act of 2012 and policies put into place through the 2014 Final Rate Notice have reduced payments to plans. The additional 6% cut proposed in the 2015 Advance Notice would further reduce payments to plans. The combined impact of these cuts may result in a significant upheaval in

the MA market, including the potential for plan exits, reductions in service areas, reduced benefits, provider network changes, and reduced MA enrollment.

6. Do you believe if the proposed cuts will disproportionately impact the elderly living in rural setting? Why/why not?

Response:

We did not specifically compare urban and rural areas in the report. However, the report identifies the proposed cuts in the 2015 Advance Notice would disproportionately affect beneficiaries with low incomes, including the 41 percent of MA enrollees who have annual incomes below \$20,000, many of which live in rural areas. Additionally in state-by-state analysis we found several states which have significant rural populations such as Alabama and Texas (see map below) are among the most affected by the changes proposed in the 2015 Advance Notice.

Map: Estimated State Impact of Proposed Reductions to 2015 Medicare Advantage*

